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PSYCHIATRY AND GENERAL PRACTICE

AN ORIENTATION

JOHN D. CAMPBELL, M.D.

NEW YORK

Any specialized branch of medicine which fails to provide for a mutual understanding between itself and other branches will become stifled with its own unpractical theories. Ultimately new ideas are tested at the bedside, and this holds true for psychiatry as well as for other branches. Psychiatry needs help from general physicians, specialists and research workers, and in return it has much to offer. The lack of understanding between psychiatry and the other branches of medicine is due to several factors which will be discussed here. As a general physician who has undertaken the study of neuropsychiatry, I feel that I am in a position to point out the causes for this lack of understanding. Unfortunately there is too much institutional red tape to allow the state hospital psychiatrists to maintain a liaison between their work and those in the active practice of medicine.

Part of the misunderstanding arises from the fact that psychiatry is a new branch, that there are several schools of thought, and that the average physician does not have the time to investigate for himself. The general attitude is well reflected in the words of a capable surgeon of my acquaintance, who said of psychiatry "I have not been able to make up my mind whether there is anything to that stuff or not."

One school stresses behaviorism, another repressed ideas, another dissociation of ideas, another individual psychology or inferiority complexes, another analytic psychology and still another objective psychobiology. Each of these schools has exerted and is now exerting its influence on modern psychiatry. No science was born in a day and each has its history of men, contributions, setbacks and new discoveries. The wise psychiatrist is aware of all these schools of thought and applies them according to the case in hand, just as the internist decides between medicine and surgery in each case of gastric ulcer.

PSYCHIATRIC EDUCATION

The psychiatric slant, insight or approach is knowledge that seems to be born in a few but is learned by most physicians by hard work and study. It gives the physician an advantage which places him above the average. One such physician, a general practitioner without any psychiatric training, recently died in an Eastern city. Almost immediately no less than a half dozen of his patients were seen at a psychiatric clinic. That man, by means of patience, understanding and a self-developed psychiatric insight, was able to keep those patients adjusted. He would have resented being called a psychiatrist, but he certainly had developed a psychiatric approach. Other physicians, without training and without a natural tendency for psychobiology, strive hard in medicine and are experts in the scientific phase of their work but neglectful of what I choose to call the art of practicing medicine. How is this psychiatric point of view to be developed?

The medical student today is being given more adequate courses in psychiatry. The work is begun in the academic schools with general normal psychology and is followed in the medical years with psychobiology and lastly psychiatry. Too many courses of the past plunged the student abruptly into psychiatry with no psychobiologic background. Between the two it seems to me that the latter is more important to the physician than the former. Psychiatry courses teach about the frankly psychotic patients who are usually sent immediately to special institutions. Psychobiology, on the other hand, is the subject that gives one a better understanding of everyday people, neurotic patients and patients on the borderline between normal and abnormal. For those who did not study these illuminating subjects in their medical courses I recommend some of the good works now out on psychobiology. William A. White, G. W. Henry, C. M. Campbell and others have written books that would be a delight to any man in the general practice of medicine. Not only will such knowledge help the physician to understand his patients more completely but he will learn to derive a greater pleasure from his practice. Incidentally, some physicians might also be able to improve on their own personalities.

There should be more cooperative work between medical men in each state and their respective state hospitals. There is an abundance of material there for their psychiatric education. Young men, before graduation, could spend a profitable summer in such an institution as clerk, attendant or nurse. State hospital staffs should arrange annual graduate courses of a few weeks for those who care to widen their medical training. Men who have thus acquired a psychiatric insight could be of help in seeing patients on parole from state hospitals in their part of the state. No physician would find this a waste of time, and his psychoneurotic patients would begin to note in him a new feeling of sympathy and understanding. It has been truthfully stated that a knowledge of psychologic medicine would be the greatest force in the prevention of socialized medicine.

PSYCHONEUROSIS

Today as always one of the most important problems to both the psychiatrist and the general physician is that of psychoneurosis. One does not solve a problem

From the Buffalo State Hospital, Buffalo, N. Y.

by making sarcastic remarks. The physician is rationalizing, says the psychiatrist, when he dismisses a patient by saying "she is just another neurotic." The physician who has been trained in cellular pathology and bacteriology finds it difficult to understand the psychoneurotic patient in the light of this training. He must learn to analyze the neurotic symptom. It is an actual disturbance dependent on changes in three definite and important systems of the human body. I will try to show that the neurotic symptom is a dysfunction, involving to a varying degree the endocrine system, the sympathetic nervous system and the psyche (mind or central nervous system). As an illustration, take an ordinary fear reaction. Through the central nervous system a danger (a fire or a gangster) is perceived; through the sympathetic nervous system the adrenals are stimulated to produce epinephrine, more dextrose is released into the blood and the person is prepared for defense or escape. This is a normal functioning of the three systems mentioned and is one which every one is aware of. Another psyche-sympathetic endocrine reaction, and one which more nearly approaches the neurotic symptom, is that of blushing. Embarrassment, which is outwardly manifested in blushing, is a reaction involving a certain association of ideas in the mind about which the individual is particularly sensitive. As a result of this mental disturbance the sympathetic nervous system is stimulated and, probably with some assistance from the endocrine system, the cutaneous blood vessels are dilated. Blushing is a simple but definite emotional reaction not unlike the neurotic reaction except in its simplicity. Like the neurotic symptom it is instigated by a repressed sensitive thought or idea, and also like the neurotic symptom it is beyond the control of the subject. It is also of concern to the sufferer in some cases, and yet one could not tell him to "forget it." One of my patients, an intelligent person, was able to connect his insomnia and "night sweats" with certain painful and sensitive thoughts which stimulated his abnormally keen sympathetic nervous system.

Such an association of ideas may likewise stimulate the sympathetic system to act on the glands of internal secretion to produce a hyperchlorhydria and thereby produce a typical pain of gastric ulcer. The patient feels the pain; it is a functional but actual symptom and deserves attention. The sufferer cannot be accused of "putting on" any more than one could accuse the blusher of shamming his sympathetic reaction. Some writers have aptly compared the neurotic symptom to a referred pain. Just as the referred epigastric pain is a symptom of appendicitis, so may the neurotic pain be an outward manifestation of a repressed painful thought.

Those who prefer this psychophysiologic explanation of neurotic symptoms will find sufficient evidence to substantiate their views. Wechsler [1] said:

> All the facts thus far accumulated point to a reciprocal relationship between the glands of internal secretion and both the vegetative and cerebrospinal nervous systems. It is not altogether established whether the nervous system controls the internal secretions or the ductless glands primarily influence the nervous system. The latter is relatively older phylogenetically, and its presence can be demonstrated in lower forms before there is any vestige of ductless glands. However, there is an undoubted hormonal as well as neural relation between the two systems. The intimacy of the relationship is attested morphologically, anatomically, physiologically, pharmacologically and clinically. It is a well known fact that psychic impulses, mediated through the nervous system, influence the activity of the glands of internal secretion and may give rise to perverted and diseased function. Intense emotions of rage, terror and anxiety may cause hyperthyroidism or glycosuria.

1. Wechsler, I. S.: Clinical Neurology, ed. 3, Philadelphia, W. B. Saunders Company, 1935, p. 661.

The frequency with which endocrine disturbance is observed in mental patients must have some significance. It is said that more than one third of the schizophrenic patients show such disorders.[2] Involutional psychosis is beyond doubt closely associated with endocrine changes.

The following case from my general practice illustrates the influence that the endocrine system exerts on mental conditions:

> CASE 1.—W. B., aged 21, was the youngest daughter of a teacher in a small town. She was of a quiet and retiring disposition. She had always shown a tendency to be overweight. Her skin and features were coarse. While taking a nurse's training course away from home she was observed to stare into space, keep to herself and eat food left from patients' trays. Examination revealed a slow pulse, mental depression and a low metabolic rate. Thyroid extract caused the patient to become more animated, show more interest and lose weight. She was advised to stop training. Seven months later she presented herself complaining of overweight. She was observed to be more depressed and retarded than her complaint would justify. But again the patient showed improvement on thyroid extract. At the present time she is adjusting well.

It is difficult to say just what kind of mental reaction this is. Psychoneurosis and reactive depression must be considered. Many hospitals would place her immediately in the schizophrenic group. At any rate the case illustrates the close connection between the endocrine system and the mental dysfunction. Those who see these early mental conditions should view the patient from all angles and as a last resort make a diagnosis of a malignant mental disease.

It is erroneously supposed that the neurotic individual could prevent or forget his symptoms if he only cared to do so. The neurotic symptom is itself a by-product of a sincere attempt to overcome a more serious problem. It is a substitution, a replacement of a formidable difficulty by a simpler one. One cannot accuse the neurotic patient of not trying to overcome his illness. The fact is, he attacks a much more serious, more deeply seated problem and is finally able to effect a compensation, so that when the physician is confronted with a simple neurotic symptom he should visualize the agonizing battle which occurred within that patient before the symptom was evolved. Jastrow [3] said:

> To call them imaginary is a crude and ignorant and, in practice, an unjust misreading of the victim's responsibility. The neurasthenic has to fight for every inch of health and poise and, when he wins, deserves a hero medal, for he is a fighter under the unfairest handicaps that could be imposed; he has the hardest task with the least energies to meet it.

Another reason for impatience with the neurotic individual should be considered: A physician expects his patients to return not with the same story of woe but with a report of improvement. When this report is lacking, visit after visit, he begins to feel inadequate and guilty, and consequently he projects this feeling back on the neurotic patient. This is the cause of the defensive expression "just another neurotic." The phy-

2. Wertham, F. I.: The Incidence of Growth Disorders in 923 Cases of Mental Disease, Arch. Neurol. & Psychiat. 21: 1128 (May) 1929.
3. Jastrow, Joseph: Clinical Psychology and Psychoneuroses, in Bentley, Madison, and Cowdry, E. V.: The Problem of Mental Disorder, ed. 1, New York, McGraw-Hill Book Company, 1934, p. 322.

sician need not reproach himself if his neurotic patient does not improve in the same way his other patients do. The neurotic patient is not blaming any one but is only looking for a sympathetic, understanding listener.

Physicians who work on the foregoing principles will soon find themselves dropping the word neurotic from their vocabulary and using instead such phrases as menopausal depression, hypothyroidism, mild involutional melancholia and hyperchlorhydria due to psychogenic factors of unknown origin.

PSYCHOANALYSIS

In the first section of the article the various schools of psychology were mentioned. At this point I wish to discuss one particular school that of "repressed ideas" or psychoanalysis, because it has tended to overshadow its mother subject and led many to believe that it dominates the whole field. Still speaking as a general practitioner with a knowledge of psychiatry, I hope to clear up some of the misunderstanding between psychiatry and other branches of medicine. Unfortunately, some psychiatrists and psychoanalysts consider their work too complicated for the average physician and attempt to place themselves on a pedestal by confusing the subject with useless phraseology. Again I maintain that a specialty cannot be built except on the understanding and cooperation of the man at the bedside. Knowledge of psychoanalysis, like other psychiatric methods, has a place in the hands of the general man, and it is for the psychiatrist to effect an understanding.

Sigmund Freud, anatomist of Vienna, in 1888 watched the neurologist Charcot attempt to cure hysteria by hypnotism. Many of the patients returned with their symptoms converted to another part of the body. Freud saw that the underlying cause of the hysteria was not being cured by Charcot's hypnotism. He also tried hypnotism in the treatment of certain neurotic conditions and, as a result of his experiments, was able to prove that human beings possess an unconscious mind. This fundamental discovery had been recognized by philosophers [4] before the time of Freud, but it had a special significance to the medical man. His subsequent work and contributions were built on a more thorough study of the unconscious mind. He found that it used symbolisms, that it paraded in our sleep as dreams and that it had a great deal to do with the lives of neurotic as well as so-called normal persons. It was while studying the unconscious mind that Freud recognized that sexual strivings play an important part in the life of man and that they begin to show their influence not at puberty but at birth. Incidentally, Freud's words on sex are scanty as opposed to the popular belief that his whole school of thought is based on sex. It is to Krafft-Ebing, Havelock Ellis and others that we are indebted for a thorough study of that phase of man.

Having proved the presence of the unconscious mind, Freud evolved the idea on which psychoanalysis is based, that painful ideas and unacceptable wishes, from early childhood, are repressed into the unconscious mind and later make their appearance transformed into outward manifestations which are called neurotic symptoms. Why some people are able to change these painful ideas comfortably into less painful ones, whereas others cannot be so successful, Freud has not been able to explain. Perhaps endocrine and sympathetic dysfunction may have some bearing on this psychophysiologic mechanism. At least Freud stated that his theory was not incompatible with an organic or physiologic explanation. Unfortunately, we have too many enthusiasts who blindly study the freudian mechanisms without trying to find a physiologic explanation for them. It is said that the patient is suffering from an unconscious death wish against the male parent, or, since there was a homosexual arrest in the psychosexual development of another patient, he became neurotic. Going over the same mechanisms day after day, patient after patient, for the last fifty years has been interesting enough for psychiatrists but has tended to separate their work from the rest of medicine.

Besides, these are not fundamental etiologic explanations. They are true observations, and without Freud's ideas we would still be groping in the dark. But are they primary causes? It is as if one discussed the rose spots of typhoid or the night sweats of tuberculosis in a sense that they were fundamental. I maintain that they are interesting phenomena and bear some relation to the disease, but what are rose spots and night sweats compared to the discoveries of Eberth and Koch?

At the present time there is a tendency to develop a physiologic explanation of the neuroses. Even back in 1921 Kempf [5] attempted a beginning in this direction. He said: "Freud's discovery that the [repressed] wish is the dynamic factor in the personality, as one feels it in himself, did as much for psychology and psychopathology as Darwin's theory of evolution did for biology. The next logical development is to account for the physiological nature and origin of the wish. Most freudians do not try to explain it." Kempf gave as the physiology of the wish (which is the dynamic principle of all behavior) the stimulation and counterstimulation of different segments of the autonomic apparatus. Within the latter he included the endocrine system, all smooth musculature and the sympathetic nervous system. He based his ideas on the experiments of Pavlov, Cannon, Watson and Sherrington as well as on his own clinical observations.

Tendencies today are pointing again toward research in chemistry, physiology and endocrinology for an explanation of the neuroses. A recent book, "The Problem of Mental Disorder," [6] gives a relatively small space to psychologic theories. Neurology, biology, physiology, chemistry, neurocytology, neural integration, nutrition and vitamins are the subjects attracting the attention of workers today. No doubt the profession in general will find in modern psychiatry much that can be used in everyday practice.

As Freud [7] returned to Europe from his one trip to America he expressed the belief that Americans were overlooking the real gist of psychoanalysis. Undoubtedly there was misunderstanding concerning his ideas, and apparently Freud was looking into the future. Certain enthusiasts, some of whom were poorly adjusted themselves, immediately connected psychoanalysis with sex perversion and voodooism, causing the scientific medical man to beware of its influence. Today, however, Freud's teachings are becoming settled to their practical application. Our best analysts recognize and speak of its limitations, but all psychiatrists feel indebted to psychoanalysis not only as a method of treatment but as a school of psychology. It is a psychology which

4. Leibnitz, Herbart and Spinoza.

5. Kempf, E. J.: Psychopathology, ed. 1, St. Louis, C. V. Mosby Company, 1920, p. 5.

6. Various authors in Bentley and Cowdry.[3]

7. Wittels, Fritz: Sigmund Freud, London, George Allen & Unwin, Ltd., 1924.

guides us in our histories, care, treatment and interpretation of patients and their problems. Orthodox psychoanalysis itself is comparable to research in other lines, and as various mental mechanisms are uncovered in the psychologic laboratory the psychiatrist has more with which to work.

For those who do not care to study the unconscious with Freud as their teacher, I recommend the great literary men who were the first psychologists and learn from them indirectly how the unconscious mind directs conscious activities. Follow Becky Sharp with Thackeray or Lord Jim with Conrad for some beautiful psychologic observations. The unconscious death wish was well expressed by Bernard Shaw in the hell scene when Don Juan says "You may remember that on earth—though of course we never confessed it—the death of any one we knew, even those we liked best, was always mingled with a certain satisfaction at being finally done with them." Such lines as Gertrude's in Hamlet "the lady doth protest too much, me thinks" serves to illustrate Shakespeare's intuitive feeling about human behavior.[8]

The general physician will find a study of psychoanalysis to be gratifying to his professional outlook as well as to his everyday enjoyment of life. Psychoanalysis of the family[9] should be of particular interest to the general physician. He is in an ideal position to observe a family over a period of years. The hysterical daughter, though married, still within the shadow of the domineering mother, is an example. The stern grandfather, the sacrificing mother, the neurotic daughter, the drunkard son, the well adjusted cousin—all these parade before the eyes of the family physician. He can watch the little child, as she trudges along to kindergarten, trying to adjust life's problems to the maladjustments of those at the family fireside. And the family physician, who has insight into these important relationships, is in an enviable position to suggest here and there and perhaps save a susceptible child from a miserable life of neuroticism. Knowledge of psychoanalysis can be made a useful ally of every medical man.

As a sailor who does not believe the world is round is obliged to sail his ship, using a round world for his plots and guides, so shall the physician who does not believe in psychoanalysis be obliged to use that school of thought as one of his adjuncts in taking histories, studying patients and their families, as well as in advising treatment.

DEMENTIA PRAECOX

Lastly, I wish to speak of the dementia praecox patient and his relationship with the medical profession. In our medical course we were taught about the well developed case of peritonitis, with boardlike rigidity and shocked facies. But in practice we are not so concerned over such a patient, who is doomed to die anyway, as we are with the early, mild case of localized peritonitis. So it is in psychiatry. The textbook picture of dementia praecox shows a person with a well developed delusion of persecution, hearing voices and receiving messages through a radio carried in his abdominal cavity. But we are told little about the mild cases of dementia praecox, the patient with only one symptom, and that carefully guarded by an evasive personality. The markedly psychotic patient is sent to an institution, but the mild cases are those seen every day by the general physician. The meagerness of psychotic material expressed by some well developed schizophrenic patients is a thing not generally realized. It is said that some paranoid praecox patients are to be recognized as much by what they fail to say as by what they do say. To overlook such a diagnosis might result in serious consequences. The following is a case from my general practice which illustrates the point:

CASE 2.—Mrs. E. C., aged 32, came for antepartum care in the sixth month of her fifth pregnancy. She showed no psychotic symptoms at that time; she was simple in her behavior, but this was discredited because of her lack of education. She always called me by my first name; she had also called her previous physician by his first name. (If this clue had been followed at the time no doubt some delusional idea concerning her physicians could have been uncovered.) The patient's labor was uneventful. One year later the new baby had pneumonia. Hospitalization was not permitted and the baby's progress was unsatisfactory. After the baby's death the mother stated that she had received messages over the radio for the care of the baby. This was the first and only frankly psychotic symptom expressed by the patient. I had difficulty in convincing the husband that his wife was psychotic. A few months later she became disturbed and was committed to a state hospital, where the diagnosis of dementia praecox was made.

The following case is offered as an illustration of what frequently happens to mildly psychotic persons. The records of any state hospital will show that this case is not an exaggeration but rather typical of what occurs when nonpsychiatric internists and surgeons are confronted with mild psychoses.

CASE 3.—C. S., a man aged 25, complained of vomiting attacks of six years' duration. The patient's father had been an epileptic with psychosis and died when the patient was 3 or 4 years old. Our patient was in the eighth grade at 15 when he began to stutter and have difficulties at school. He then quit school and worked at various jobs; he was a clerk in a wholesale drug firm and a laborer in a garage and later played a saxophone in an orchestra. In September 1926, when he was 19, he began to vomit, especially in the presence of other people. He had always been of a quiet, seclusive disposition, and at this time these traits became more pronounced. He lost weight and his hands became "cold and bluish." He was seen by several physicians and given medicine with no relief. The vomiting continued and he frequently withdrew to his own room when there was company in his home. Finally it became an effort for him to eat with his own family, and he would perspire when attempting to do so. A surgeon was consulted, and in January 1927 the patient was operated on for gastric ulcer. A gastro-enterostomy was performed and the patient made an uneventful recovery from the operation. No improvement occurred, but the patient obtained employment, which he was able to keep for about eight months. The vomiting persisted and his condition continued about the same for the next three years. In 1931 he was seen in a city hospital clinic, where a psychiatrist advised him to try living in the country. He lived on a farm practically alone for six months. In February 1932 he returned to the city, reporting to the psychiatrist that there was nothing left for him but suicide. He was committed to a mental institution.

On admission to the Buffalo State Hospital the patient was quiet, shy and seclusive but cooperative. He was depressed; he said that he had been examined by twenty-three doctors and that suicide was apparently the only way out. He stated that he did not have hallucinations but did say that he had been called vile names by his fellow workers, and he had felt that people on the street were talking about him. He requested that he be permitted to eat in his own room but was told to mix with the other patients and attempt to eat with them. He had a feeling of uneasiness when eating in the presence of others and frequently vomited soon after meals. The patient's history and problems were discussed with him in a sympathetic manner. He was told that his vomiting was of nervous origin

8. Jones, Ernest: Essays in Applied Psychoanalysis, London, International Psychoanalytical Press, 1923.
9. Flugel, J. C.: The Psychoanalytic Study of the Family, London, Hogarth Press, 1926. Kempf.[5]

and that he could overcome it by gradually adjusting himself to his environment. On one occasion he requested an interview with the physician and was found to be worrying over masturbation. Other sexual problems were discussed with him, and he seemed much relieved. He liked the hospital and stated that it was the only place where he had found any relief. He exhibited mannerisms and presented a slightly inadequate emotional reaction. Briefly, the patient made a good hospital adjustment. A diagnosis of dementia praecox was made. He has now been in the hospital six years. Whenever parole or discharge is suggested to him he begins to vomit. He is a good worker, pleasant and agreeable, and takes a part in the hospital orchestra.

Several significant points stand out in this case. The underlying personality of this individual was either overlooked or its importance was not recognized by at least a dozen physicians. The definite mental symptoms accompanying his chief complaint were apparently discarded as unimportant. A threat of suicide was necessary before he could obtain sympathetic consideration. A final observation here is the small amount of consultation necessary for this patient to make a fair adjustment.

700 West 168th Street.

PELLAGRA OF KENTUCKY MOUNTAIN FOLK

AMBULATORY TREATMENT WITH NICOTINIC ACID

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CINCINNATI

Since remarkable results of nicotinic acid treament of acute pellagra have been reported from numerous sources [1] it naturally follows that the same treatment should be tried in recurrent and chronic forms of the disease as seen in an ambulatory clinic. The application of dietary measures, even with the aid of yeast, has not been satisfactory with the ambulatory patient. Now, with an inexpensive and easily administered remedy, so-called control of the disease could be attempted. At the invitation of the Frontier Nursing Service, Inc., of Kentucky and the Health Department of Perry County, the treatment of ambulatory cases among mountain folk was started in April 1938 in a public health clinic. The study and methods of treatment were similar to those used by the University of Cincinnati, under the guidance of Dr. Tom D. Spies, at Birmingham, Ala.[2] Unlike the clinic treatment recently described from Augusta, Ga.,[3] our method of therapy attempted to fit the dosage to individual cases and to the complaints, and therefore much larger amounts were given.[4]

Perry County lies in the southeastern part of Kentucky and in 1930 had a population of 42,186. Its largest town has a population of 7,061. The chief industry of the town and county is coal mining. The coal miners are, in the main, mountain folk who cling to the traditional diet of syrup, corn meal and fat meat. Combined with this is the fact that they are no longer farmers. They usually have the customary miner's cabin, with a small plot of ground, and go as the coal industry goes. The county population otherwise is rural, of the mountain type. Pellagra has been endemic here for a long time. These circumstances of dietary habit and economic isolation were ideal for therapeutic trials, for neither the patient nor the physician could do anything about changing the diet.

The majority of the patients who attended the clinic were referred by local physicians who were interested in the nicotinic acid study. Others were referred by patients who were receiving treatment. Only those patients who gave evidence of active pellagra were selected for treatment.

The material of the study (from May 15 to Nov. 1, 1938) is summarized in table 1. In the main, table 1 is self explanatory except that two patients were from the same family—mother and daughter. There was an uncommonly large proportion of multiparous women. On the first visit to the clinic a definite history of pellagra was obtained. The course of the present attack was recorded in chronologic sequence. The dietary history included the type and amount of food consumed and the source of the food supply. Associated conditions and diseases that might be contributory also were listed. Further notations were made about the patient's physical status. Subsequent visits, at weekly intervals, included general observations about the patient's course, weight, blood pressure, pulse rate, state of dermal lesions and visible mucous membrane lesions. Neurologic examinations were done as indicated by subjective observations. Tendon and muscle reflexes were elicited as well as proprioception, touch, pain and pressure. Further examinations were done as time and facilities permitted.

"Duration of disease" is given in terms of onset of the first symptoms of the current attack in weeks prior to the first visit. In the majority of cases the onset of the dermal lesions and the onset of the disease coincided. In others, general subjective symptoms or diarrhea began from one to eight weeks prior to the onset of other symptoms.

"Previous attacks" show recurrent and initial attacks, twenty-four and seventeen respectively. One notes previous attacks ranging from one to ten, with a child aged 10 years having its fourth recurrent attack.

Under "associated conditions" are listed miscellaneous data such as nursing mothers (six) and those having menopausal symptoms (seven). Several had hypertension in contrast to the expected normal of hypotension.

Only the pellagra-preventing types of food are tabulated under "diet." This is done with the full realiza-

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The Perry County Health Officers and their staff helped in this work as well as the physicians who sent patients to us. We were aided by Miss Marion Ross, statistician of the Frontier Nursing Service, Inc.

1. Reports have been published by:
Fouts, P. J.; Helmer, O. M.; Lepkovsky, Samuel, and Jukes, T. H.: Treatment of Human Pellagra with Nicotinic Acid, Proc. Soc. Exper. Biol. & Med. **37:** 405 (Nov.) 1937.
Harris, Leslie: Nicotinic Acid and the Pellagra-Preventing Vitamin, Nature **140:** 1070 (Dec. 18) 1937.
Smith, D. T.; Ruffin, J. M., and Smith, Susan G.: Pellagra Successfully Treated with Nicotinic Acid, J. A. M. A. **109:** 2054 (Dec. 18) 1937.
Spies, T. D.; Cooper, Clark, and Blankenhorn, M. A.: The Use of Nicotinic Acid in the Treatment of Pellagra, ibid. **110:** 622 (Feb. 26) 1938.
Rachmilewitz, M., and Glueck, Helen I.: Treatment of Pellagra with Nicotinic Acid, Brit. M. J. **2:** 346 (Aug. 13) 1938.

2. Spies, T. D.; Bean, W. B., and Stone, R. E.: The Treatment of Subclinical and Classic Pellagra: Use of Nicotinic Acid, Nicotinic Acid Amide and Sodium Nicotinate, with Special Reference to the Vasodilator Action and the Effect on Mental Symptoms, J. A. M. A. **111:** 584 (Aug. 13) 1938.

3. Schmidt, H. L., and Sydenstricker, V. P.: Nicotinic Acid in the Prevention of Pellagra: A Preliminary Note, J. A. M. A. **110:** 2065 (June 18) 1938.

4. The nicotinic acid used in this study was furnished by Dr. Isaac F. Harris, director, the Harris Laboratories, Inc., Tuckahoe, N. Y.

tion of the many discrepancies that exist between food reported consumed and food actually consumed. As a rule, the tendency was to conceal the facts about the scarcity of adequate fresh foods. Local farms are known to be limited in size and fruitfulness, save in a corn crop. Mining income was markedly limited in this particular season (employment only up to three days a week). The food supply came from the general store or the company store. The chief food articles purchased are dry salt bacon, lard, flour and bolted meal, sugar, coffee and beans (pinto and navy).[5] Miners in mining sections are frequently obliged to purchase from the so-called commissary, which is more expensive and offers a restricted supply of fresh foods. Gardens, chickens and cows furnish further supplies. Thirty patients reported gardens of varying sizes, five as having a cow and eleven as keeping chickens. The mining group had fewer supplements of this nature. In general, the consumption of vegetables seemed to be adequate among most of the patients having a limited intake of milk, eggs and meat.

Table 2 relates the clinical story. There seem to be any number of combinations characterizing the onset. The usual story is one with a slowly progressive group of nondescript complaints which frequently are of weeks' duration, increasingly severe, until the appearance of objective signs. In other individuals the onset is occasionally objective. All the items listed are observations and complaints made on the first clinic visit. A patient was listed as having mental symptoms if he was confused or incoherent or had hallucinations or delusions. We think that such symptoms are more frequent than is usually stated.[6] Tachycardia was noted as such after a persistent pulse rate in excess of 100 a minute.

The last three columns list the patients in terms of severity of their disease as acute (eleven), subacute (twenty-two) and chronic (six). Two cases were considered subclinical (36 and 39). Of the eleven acute cases, seven were recurrent. The dermal lesions were the chief factor in this attempted classification because of their preponderance.

The clinical course of the patients varied markedly. Dermal and mucosal lesions responded to treatment in a dramatic manner. New and severe lesions cleared up

TABLE 1.—*Descriptive Data*

Case	Age	Sex	Gravida	State of Nutrition			Diet Pellagra-Preventing Foods*				Duration of Disease, Weeks	Previous Attacks	Associated Conditions
				Poor	Fair	Good	Milk	Meat	Eggs	Vegetables			
1	45	♀	12	..	..	+	0	+	0	++++	1	0	Climacteric
2	18	♀	1	..	..	+	++++	++++	0	++++	8	0	
3	8	♀	..	..	+	..	+	+	0	++	1	0	
4	36	♀	7	+	..	..	+	+	0	++++	8	10	Nursing mother
5	42	♀	8	..	+	..	0	0	+	++++	9	6	Climacteric; Parkinson's disease
6	30	♀	10	+	..	..	0	+	0	++	16	0	Nursing mother
7	30	♀	8	..	+	..	+++	0	++	+++	8	6	
8	28	♀	8	+	..	..	0	0	+	++++	8	3	Nursing mother
9	35	♀	9	..	+	..	0	+	0	++	6	0	Nursing mother; hypertension
10	18	♀	..	+	..	..	0	+	0	++++	6	0	
11	10	♀	..	..	+	..	+++	+	+	+	4	3	
12	32	♀	6	..	+	..	0	+	ND*	+	16	1	
13	37	♀	10	+	..	..	+	0	ND	+++	3	0	
14	36	♀	6	+	..	..	0	0	+	+	12	1	Hypertension
15	35	♀	3	+	..	..	++	++++	++++	++++	2	5	
16	65	♂	..	..	+	..	++	+	+	++++	8	0	
17	29	♀	5	..	+	..	++	+	ND	++	4	0	
18	16	♀	..	..	..	+	0	+	++	++	16	1	
19	33	♀	4	+	..	..	0	0	+	++++	6	1	
20	42	♀	6	+	..	..	0	0	++	++++	6	4	Heart disease; hypertension
21	44	♀	8	..	+	..	0	0	ND	++++	4	1	Climacteric
22	27	♀	4	+	..	..	0	++	0	+	2	1	
23	30	♀	7	+	..	..	0	++++	++	+++	3	0	
24	34	♀	..	..	..	+	+	0	+	++++	4	1	
25	28	♀	6	..	+	..	0	+	+	+++	16	0	Nursing mother; hypertension
26	38	♀	6	..	+	..	ND	ND	ND	ND	..	0	Climacteric
27	36	♀	5	+	..	..	++	+	+	++++	4	6	
28	41	♀	10	+	..	..	+	0	+	0	..	1	Chronic diarrhea; marked hypertension
29	51	♀	9	..	+	..	++	0	0	++++	3	0	Climacteric
30	44	♀	5	+	..	..	+++	+	++++	++	4	7	Psychosis with a previous attack
31	26	♀	..	..	..	+	++++	++	0	++	4	0	Upper respiratory infection
32	45	♀	8	+	..	..	++	+	+	0	11	0	Climacteric; syphilis
33	25	♀	2	..	+	..	+	0	0	++	3	0	
34	36	♀	5	..	+	..	0	+	0	++	4	4	
35	30	♀	7	..	+	..	+++	0	++	+++	1	1	Hypertension
36	36	♀	6	..	+	..	++	+	++++	++	..	2	Climacteric
37	33	♀	9	..	+	..	ND	ND	ND	ND	3	3	Nursing mother
38	41	♂	..	+	..	..	0	+	0	++	8	3	Alcoholic
39	51	♂	..	+	..	..	0	0	+	+++	4	0	
40	75	♂	..	+	..	..	0	+	0	++	8	3	
41	48	♂	..	+	..	..	0	+	+	++	..	1	
Total	5 ♂, 36 ♀		30	19	17	5	..	..	..	..	..	24	

* Pellagra-preventing foods: Milk, +, one glass occasionally a week; ++++, three to four pints a day. Meat, +, occasionally each week; ++, for breakfast regularly; ++++, two or three times a day. Eggs, +, irregularly; ++, once a day; ++++, two or three times a day. ND, no data.

5. Sources of income: mines sixteen, relief agencies thirteen, farms seven and general labor five.

6. Spies, T. D.; Aring, C. D.; Gelperin, Julius, and Bean, W. B.: The Mental Symptoms of Pellagra: Their Relief with Nicotinic Acid, Am. J. M. Sc. **196**: 461 (Oct.) 1938.

more rapidly than old chronic lesions. But despite the inactivation of these lesions, complaints such as itching skin, hot mouth and burning stomach often continued. Most of the patients lost weight for the first two or three weeks. Blood pressure changes were uniform in that they all tended to be lowered. Several were extremely low while others, previously high, approximated normal levels under treatment. In two instances, diarrhea was found to antedate the usual early manifestations from one to three months. Nicotinic acid was not satisfactory in checking the diarrhea of this type of patient, but the presence of the diarrhea did not influence the therapeutic response otherwise. We think that in this circumstance diarrhea was the cause of pellagra and not a necessary part of the disease. Menstrual function was restored in several patients with ensuing pregnancies. The menopausal age group had the most intense subjective reactions. All the patients felt stronger, had less burning, slept better or were less nervous after the first (thirty-one patients), second (six patients) or third week (three patients) of treatment.

Table 3 deals with treatment and results. Nicotinic acid was always given in the form of 50 and 100 mg. tablets. A supply for one week was given, with instructions that the tablets were to be taken at meal time. This method of medication had previously been found to minimize certain reactions to the drug.[2] None of our patients complained of any difficulty in taking the substance. The question of adequate dosage is one on which further study is indicated. In general, it has been our experience that doses of from 150 to 200 mg. a day were adequate, if maintained for two or three weeks, after which time the amount could be decreased until the patient was symptom free. For other individuals the initial dose had to be increased markedly (up to 800 mg.). For still others, further increases in amount of medication were required, the chief index as to dosage being the state of the objective manifestations and the patient's complaints.

The estimation of "results" is given in terms of changes in weight and clinical improvement. Changes in weight are given as gains and losses (first clinic weight compared with last clinic weight). Improvement is shown as complete, partial or unchanged. Under "complete" are listed twenty-eight patients who are free from objective and subjective signs of pellagra. Under "unchanged" is one patient who was treated for one week only. Under "partial" are listed twelve patients who still have complaints. In analyzing the partial improvement group one finds two complaining of general nervousness, one of itching, one of gastric burning, two of persistent diarrhea, two of weakness, one of faulty memory and one of burning in the extremities. One had a recurrence of skin lesions which responded to increased medication. This group also includes two nursing mothers, three patients in the climacteric period and five patients who had mental symptoms.

Under "notations" are listed miscellaneous items such as complaints which persist, associated conditions and other factors which had clinical significance. It

TABLE 2.—*Clinical Observations*

Case	Constipation	Diarrhea	Vomiting	Loss of Strength	Anorexia	Glossitis	Stomatitis	Vaginitis	Mental Symptoms	Tachycardia	Dermatitis*	Acute	Subacute	Chronic
1	....	....	....	....	Yes	Yes	....	....	....	....	+++	+	..	..
2	....	Yes	....	Yes	Yes	....	....	....	....	Yes	+	..	+	..
3	....	....	....	....	Yes	....	....	....	....	....	+++	+	..	..
4	....	Yes	....	Yes	Yes	Yes	Yes	....	....	....	+	..	+	..
5	....	....	....	Yes	Yes	Yes	....	....	....	....	++	..	..	+
6	....	....	....	Yes	Yes	....	....	Yes	....	....	+	..	+	..
7	....	Yes	....	Yes	Yes	Yes	....	....	....	....	+	..	+	..
8	....	....	....	Yes	....	Yes	Yes	....	....	....	++	..	+	..
9	....	....	....	Yes	....	Yes	Yes	....	....	....	+++	+	..	..
10	....	....	....	Yes	Yes	....	....	....	....	Yes	+	..	+	..
11	....	....	....	Yes	....	....	....	....	....	....	++++	+	..	..
12	....	....	....	Yes	Yes	....	....	....	....	....	++++	+	..	..
13	....	Yes	....	Yes	Yes	Yes	Yes	....	....	....	+++	+	..	..
14	....	Yes	....	Yes	Yes	Yes	Yes	Yes	....	....	+++	+	..	..
15	....	Yes	....	Yes	....	Yes	Yes	....	....	....	+++	+	..	..
16	....	....	....	Yes	....	Yes	....	....	Yes	....	++	..	+	..
17	....	Yes	....	Yes	Yes	....	....	....	....	....	++	..	+	..
18	Yes	....	Yes	Yes	Yes	....	....	Yes	....	....	+	..	+	..
19	....	....	....	Yes	Yes	Yes	....	....	....	....	+	..	+	..
20	Yes	....	....	Yes	Yes	....	....	....	....	Yes	++++	+	..	..
21	Yes	....	....	Yes	Yes	Yes	....	....	....	....	+	..	+	..
22	....	Yes	....	Yes	....	Yes	....	....	....	....	++	..	+	..
23	....	Yes	....	Yes	....	....	....	....	....	Yes	++	..	+	..
24	Yes	....	....	Yes	Yes	....	....	....	....	Yes	++	..	+	..
25	....	....	Yes	Yes	....	Yes	....	....	....	Yes	+	..	..	+
26	Yes	....	....	Yes	Yes	Yes	....	....	Yes	Yes	+	..	..	+
27	....	Yes	....	Yes	Yes	Yes	....	....	Yes	....	++	+	..	..
28	....	Yes	....	Yes	Yes	Yes	Yes	....	Yes	....	0	..	..	+
29	....	Yes	Yes	Yes	....	Yes	....	....	Yes	Yes	+	..	+	..
30	....	....	....	Yes	....	Yes	....	....	Yes	....	+	..	..	+
31	....	Yes	Yes	Yes	....	....	....	....	....	....	++	..	+	..
32	....	....	....	....	Yes	....	....	....	....	....	++	..	+	..
33	....	....	....	Yes	Yes	....	....	....	....	....	++	..	+	..
34	....	....	....	Yes	Yes	....	....	....	Yes	....	+	..	+	..
35	Yes	....	....	Yes	Yes	....	....	....	....	....	+	..	+	..
36†	....	....	....	Yes	Yes	....	....	....	....	....	0	..	..	..
37	....	....	....	Yes	....	....	....	....	....	....	++	..	+	..
38	....	Yes	....	Yes	Yes	Yes	....	....	....	....	+++	+	..	..
39†	....	Yes	....	Yes	Yes	Yes	....	....	....	....	0	..	..	..
40	....	....	....	Yes	Yes	....	....	....	....	....	++	..	+	..
41	....	....	....	Yes	Yes	Yes	Yes	....	Yes	....	+	..	..	+
Total	6	15	4	38	29	22	8	3	8	8		11	22	6

* Classification of dermatitis: +, residual thickening with terminal desquamation; ++, absence of red color with general scaling; +++, dull red color with central scaling; ++++, red color with or without bullae.
† Subclinical.

also includes notations as to early pregnancies, of which there were three, and several instances in which hypertension was greatly reduced.

To assess the results completely requires more detail than can be tabulated, but we are certain that twenty-eight of the forty-one patients were completely relieved of the disease with nicotinic acid and no change in diet. The twelve patients who persisted with complaints are described at greater length and, in the main, loss of weight or insignificant gain is recorded. With one exception, the largest gains in weight occurred among those completely improved.

All of the group remained ambulatory save one (patient 28), who was sent to the Cincinnati General Hospital because of persistent diarrhea, probably due to chronic ulcerative colitis. All of the group can definitely be said to have improved on nicotinic acid alone and to have been cured clinically except for mild subjective complaints and diarrhea, which persisted in two instances (cases 17 and 27) in spite of a gain in weight. In this respect nicotinic acid can be said to cure pellagra so far as the major phases of the disease are concerned. There was one patient who had a relapse while under treatment. This patient (30) perhaps should have had larger doses; because of her mental symptoms we are not sure that she always took her medication.

There was fairly good correlation between gain in weight and other clinical signs of improvement. There was also significant correspondence between the state of nutrition and the result. All of the class who were partially relieved, i. e. persisted with impaired health, were among those described as poorly nourished or only fairly well nourished.

In this we see the disease pellagra well controlled by nicotinic acid but a considerable amount of poor health persisting. It is significant that no person who ate more of his poor diet and gained weight thereby had an exacerbation of pellagra.

CONCLUSIONS

Of forty-one ambulatory pellagrins treated in a clinic with nicotinic acid and without change of diet, twenty-eight were completely cured and remained well; twelve were partially improved, and the condition of one who was inadequately treated was unchanged.

The dosage varied according to complaints and other indications and objective symptoms. The largest average weekly dose was 2.8 Gm. and the smallest 0.24 Gm.

Eight patients showed significant gains in weight (5 or more pounds). Fourteen showed a loss of 1 or more pounds.

Nicotinic acid seems to cure pellagra even when poor diets are continued, but relapses may occur. Nicotinic acid may aid in the restoration of health, but among the pellagrins here described a considerable amount of ill health, such as anemia, underweight, diarrhea and a few subjective symptoms, persisted.

TABLE 3.—*Treatment and Results*

Case	Nicotinic Acid Dosage: Average Weekly, Mg.	Nicotinic Acid Dosage: Total Weeks	Weight, Pounds: Gain	Weight, Pounds: Loss	Number of Clinic Visits	Diet: Adequate	Diet: Inadequate	Diet: No Data	Improvement: Complete	Improvement: Partial	Improvement: Unchanged	Hemoglobin, Gm.*	Notations
1	425	2	2	..	4	..	+	..	+	..	..	....	
2	1,050	1	3½	..	2	+	..	..	+	..	..	....	
3	200	1	1	..	2	..	+	..	+	..	..	....	
4	2,800	1	..	5	2	..	+	..	..	+	..	....	Nervousness; nursing mother
5	700	9	8	..	10	..	+	..	+	..	..	10	
6	700	5	..	8	6	..	+	..	+	..	..	12	Whooping cough
7	480	6	10	..	7	+	..	..	+	..	..	10.4	
8	650	8	..	7	11	..	+	..	+	..	..	....	Upper respiratory infection
9	583	6	..	2	7	..	+	..	+	..	..	11.8	Hypertension decreased
10	350	2	1	..	3	..	+	..	+	..	..	....	
11	320	10	1	..	10	+	..	..	+	..	..	....	
12	240	10	..	3	11	..	+	..	+	..	..	....	Early pregnancy
13	375	10	2	..	12	..	+	..	+	..	..	....	Upper respiratory infection
14	707	7	10	..	8	..	+	..	+	..	..	11	Hypertension decreased
15	543	6	0	0	7	+	..	..	+	..	..	....	
16	1,011	9	1	..	8	+	..	..	..	+	..	9.4	Complains of faulty memory
17	1,830	10	1	..	9	..	+	..	..	+	..	....	Persistent diarrhea
18	962	4	..	1	4	+	..	..	+	..	..	....	
19	846	12	10	..	12	..	+	..	+	..	..	....	
20	718	13	1	..	11	..	+	..	+	..	..	11.6	Hypertension decreased; early pregnancy†
21	875	4	..	4	5	..	+	..	..	+	..	....	Burning in extremities; climacteric
22	747	8	3	..	8	..	+	..	+	..	..	....	Asthma; upper respiratory infection
23	900	9	1	..	7	+	..	..	..	+	..	....	Complains of gastric pain
24	1,050	2	..	1	4	..	+	..	+	..	..	....	
25	872	2	..	5	4	..	+	..	+	..	..	10.4	Upper respiratory infection
26	1,050	5	..	3	7	..	..	+	..	+	..	8.4	Nervousness; climacteric
27	1,724	23	20	..	24	+	..	..	..	+	..	7.8	Persistent diarrhea; early pregnancy
28	1,827	11	49	..	14	..	+	..	+	..	..	....	Interval at Cincinnati General Hospital
29	1,330	5	4	..	5	+	..	..	+	..	..	....	
30	1,178	16	1	..	15	+	..	..	..	+	..	11.6	Exacerbation of dermal lesions
31	883	3	2½	..	3	+	..	..	+	..	..	....	
32	508	6	2	..	6	+	..	..	..	+	..	....	Complains of itching; climacteric
33	466	3	..	1	3	..	+	..	+	..	..	....	
34	700	1	1	..	2	..	+	..	..	..	+	....	Treatment for one week only
35	840	5	..	6	6	+	..	..	+	..	..	....	Recent dysentery
36	350	2	5	..	2	+	..	..	+	..	..	....	Subclinical
37	483	3	3	..	4	..	..	+	..	+	..	....	Complains of weakness; nursing mother
38	1,750	2	2	..	2	..	+	..	..	+	..	....	Died two months later, "heart block"
39	1,400	6	..	4	7	..	+	..	+	..	..	....	Subclinical
40	722	13	..	1	14	..	+	..	+	..	..	10.6	
41	2,730	5	7	..	6	..	+	..	..	+	..	....	Complains of weakness; much more coherent
Total...			26	14		14	25	2	28	12	1		

* Hemoglobin on discharge from clinic (Sahli-Adams) 17 Gm. = 100 per cent.

† Miscarriage at eight weeks.

HERPES ZOSTER AND VITAMIN B_1

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Vitamin B_1, because of its antineuritic properties, has been suggested for the treatment of a host of conditions, varying from systemic diseases with neuritic symptoms to diseases of nerve tissues per se. Stevenson [1] tried it in a large group of cases and was very favorably impressed with its efficacy. He treated eighteen cases of sciatica, fourteen of neuritis, mainly of the brachial type, and three cases of general debility with vague and multiple nerve pains. He employed it intramuscularly in doses of 1 or 2 mg., giving an average total dose of 33 mg. In 40 per cent of the cases treated there was cessation of symptoms, in 37 per cent very much improvement and in 23 per cent slight or questionable improvement; and Stevenson concluded that "vitamin B_1 provides a factor often necessary for clearing up efficiently a neuritis, without which the condition would probably remain chronic."

Stern [2] too was no less favorably impressed by his experience with vitamin B_1 in a wider variety of cases. He administered it intraspinally in twenty-eight cases of intractable pain and inflammatory and degenerative diseases of the central nervous system. His series consisted of such conditions as inoperable cancer, von Recklinghausen's disease, multiple sclerosis, duodenal ulcer with pulmonary tuberculosis, Paget's disease, alcoholic neuritis of supra-orbital and sciatic nerves, spondylitis, degeneration of pyramidal tracts, beriberi, pruritus ani and vulvae, and other conditions. Improvement was noted in all of the patients; they felt better and looked better; pain in every case was lessened or abolished; the appetite improved as well as muscular control, speech and gait. The patient with von Recklinghausen's disease responded most favorably.

These and other reports, all in the same optimistic tone, led us to try vitamin B_1 for the pain of herpes zoster. Herpes zoster is generally held to be a ganglionitis produced by a virus. It is likely that there are many etiologic factors in its production, for any type of inflammation of the spinal ganglion may produce a herpetic eruption. It is probable too that the same points emphasized by Wechsler [3] regarding the causes of polyneuritis may be invoked for herpes zoster. Wechsler suggested that in many cases of polyneuritis which have hitherto been regarded as due solely to a specific cause such as alcohol, lead or arsenic (a not infrequent cause of zoster) one may find an additional and perhaps determining factor in avitaminosis. He suggested too that possibly in every case in which there is a deficiency of antineuritic and other vitamins there must be an additional toxin or poison to bring about degenerative changes. Herpes zoster differs from these other neuritides in that the disease is self limited and usually confers an immunity against subsequent attacks; it is an inflammatory disease but its many similarities to conditions which are said to respond favorably to treatment with vitamin B_1 seemed to warrant a therapeutic trial.

We were able to find recorded but two references to herpes having been treated with crystalline thiamin chloride (vitamin B_1 hydrochloride). Nitzulescu and Triandaf,[4] having obtained good results with vitamin B_1 in a case of trigeminal neuralgia, tried it for herpes of the cornea; and for two patients who suffered very severe pain, prompt relief was obtained from the first injection of thiamin chloride, and complete relief after 6 mg. (1,800 units). Neither of these patients had obtained relief from the usual antineuralgic treatment.

Vorhaus [5] treated only cases of postherpetic anesthesia and paresthesia with vitamin B_1 and his results suggested a quicker disappearance of these symptoms than by the usual methods.

For these reasons we tried the use of crystalline thiamin chloride in sixteen cases of herpes zoster. Our cases were from the dermatologic clinics of a large charitable hospital and a medical school. Of twenty-five persons we were able to follow sixteen to the point at which we felt that sufficient amounts of the vitamin had been administered to determine its efficacy.

Crystalline thiamin chloride in doses of 2,000 international units was administered subcutaneously so that there could be no doubt as to cooperation on the part of the patient. The injections were given every second or third day in a group of seven males and nine females. The results with the treatment with thiamin chloride were as follows:

Two children, aged 9 and 13 years, were completely relieved of subjective symptoms after the first injection of 2,000 units. A third child required 4,000 units. The first two children were treated on the third and seventh day of the disease respectively and the third child on the seventh day of the disease, so that one can assume that the treatment did not have a strikingly beneficial effect in these cases, for the disease acted as it usually does in children. One patient, aged 62 years, obtained considerable relief after having received 6,000 units on the fifth day of illness. Another man of 48 years reported only occasional discomfort after 8,000 units (fifth day of illness). There was no relief from the treatment in the remaining eleven cases, including two of severe postherpetic neuralgia.

Reports in the literature had led us to expect prompt beneficial results from the large individual doses and from the average total dose of 5,620 international units which we employed. In the main we were disappointed, however, for the results were neither good nor bad. Several factors may account for the results:

The majority of our patients were not young and age is often a determining factor in herpes zoster, the severity of pain and length of time varying in direct proportion to the age of the individual. Three of our patients were children, the ages ranging from 9 years to 13 years. One was 20 years of age and the remainder, twelve individuals, ranged in age from 40 years to 80 years.

The day of the disease on which the treatment was started varied from the first day in one instance to the sixtieth day in another. This too is a factor which would seem important in any evaluation of results.

The severity of the subjective symptoms also differed considerably. One patient, aged 9 years, complained

The thiamin chloride used in this study was furnished by Abbott Laboratories.

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1. Stevenson, David: Vitamin B_1 in the Treatment of Neuritis, Practitioner **140**: 301-306 (March) 1938.
2. Stern, E. L.: Intraspinal (Subarachnoid) Injection of Vitamin B_1 for Relief from Intractable Pain, and for Inflammatory and Degenerative Diseases of the Central Nervous System, Am. J. Surg. **39**: 495 (March) 1938.
3. Wechsler, I. S.: Etiology of Polyneuritis, Arch. Neurol. & Psychiat. **29**: 813 (April) 1933.
4. Nitzulescu, J., and Triandaf, Ecaterina: Treatment of Herpetic Keratitis with Vitamin B_1, Brit. J. Ophth. **21**: 654 (Dec.) 1937.
5. Vorhaus, M. G.: Present Evaluation of Vitamin B_1 Therapy, Am. J. Digest Dis. & Nutrition **3**: 915 (Feb.) 1937.

only of itching; another one, aged 42 years, stated that he had "burning, not real pain"; five patients comprising all those 68 years old or over (from 68 to 80) complained of very severe pain, and in two the severe neuralgia persisted long after the herpetic eruption had vanished. In the remaining cases, nine in number, there was moderate to severe pain. In general, however, the group was adequate for test purposes.

CONCLUSION

Our experience with sixteen cases of herpes zoster treated with vitamin B_1 (thiamin chloride) showed that the treatment gave indifferent results. In two cases of postzoster neuralgia in which we had expected and hoped for effective results there were none. Treatment with vitamin B_1 was no more beneficial than with the usual less expensive methods.

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MENINGITIS CAUSED BY STREPTOCOCCUS HAEMOLYTICUS

AND TREATED WITH SULFANILAMIDE

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GROUP 1, 1935-1936

In 1935 and 1936 eleven patients with meningitis caused by hemolytic streptococci were treated in the Division of Contagious Diseases, City Hospital, Cleveland. Ten of these patients died. Seven other patients with streptococcic meningitis who died during this period are not considered in this report because either the streptococci found were nonhemolytic (two cases) or the organisms were not grown on blood agar and hemolysis had not been demonstrated (five cases).

The ages of these patients ranged from 4 weeks to 51 years; two were adults and nine were children from 4 weeks to 6 years of age. Two patients were under 1 year of age; two were 4, two were 5, three were 6, one was 23 and one was 51 years old. In eight cases the meningitis followed acute otitis media lasting from one to seven days; one case followed cellulitis, one erysipelas of the face and another an abscessed tooth. All the patients were acutely ill and toxic on admission, two being unconscious, two delirious and one in convulsions. Their temperatures ranged between 38.5 and 40.5 C. (101.3 and 104.9 F.). All showed signs of meningeal irritation with a positive Kernig sign and so on. Lumbar punctures were done on admission to the hospital. The spinal fluids contained from 290 to 35,000 cells, predominantly polymorphonuclears. In five cases the cell count was under 800 on admission but increased rapidly to several thousand within twenty-four hours.

All kinds of therapy, such as specific antistreptococcus serums, nonspecific serums, blood transfusions, spinal drainage and drugs, were tried. The only patient who recovered was a boy aged 3½ years who had an abscess of the left forearm which was incised and drained. Blood transfusion was employed and the patient's temperature became normal on the fourth hospital day.

Five of the ten patients died in from one to three days, one in five days and the remaining four in from twelve to twenty-two days after admission to the hospital. In eight cases an autopsy was performed; mastoiditis was found in six.

From 1926 to 1934 inclusive, forty-eight of fifty patients with streptococcic meningitis died.

GROUP 2, 1937-1938

Twelve patients with meningitis caused by hemolytic streptococci were admitted to our divisions during 1937 and 1938. In ten cases cultures of hemolytic streptococci were obtained from the spinal fluid. Although streptococci were found and easily demonstrated in the spinal fluid in two cases, they did not grow on blood agar and therefore hemolysis could not be demonstrated. They probably were hemolytic, however, since the meningitis followed otitis media complicating scarlet fever, from which hemolytic streptococci had been recovered.

Eight cases of meningitis followed otitis media, one sinusitis, one an infected laceration, one cellulitis of the scalp and one septicemia with associated sinusitis.

The condition of the patients on admission and the conditions found on physical examination were essentially similar to those found in group 1.

Three patients were given meningococcus antitoxin before the diagnosis was established. All the other patients as well as these three were given sulfanilamide on the first or at least the second day after admission. The amount of sulfanilamide is calculated as maintenance and initial doses. The initial dose is one half the maintenance dose, which is calculated on the basis of the patient's weight, i. e. 1 grain (0.065 Gm.) per pound (453 Gm.) up to 120 pounds (54.4 Kg.) for the first twenty-four hours, given in divided doses every four hours. On the second and subsequent days the maintenance dose is decreased to one-half grain (0.03 Gm.) per pound and is given in divided doses every four hours. One infant received as much as 2 grains (0.13 Gm.) per pound for two days; another received 530 grains (34 Gm.) orally in twenty-four days. Occasionally the drug was given by hypodermoclysis (0.8 per cent in saline solution). It was difficult enough to give the number of tablets needed and almost impossible to give sodium bicarbonate after each dose of the drug. Only in a few cases was this even attempted. The sulfanilamide tablets were ground and swallowed with water. If the patient was unconscious the tablets were ground, water was added and the suspension was given through a Levine tube. The average length of treatment was six days. The sulfanilamide blood level at the height of treatment ranged from 5 mg. to 11.5 mg. per hundred cubic centimeters; the average was 9.5 mg.

TABLE 1.—*Summary of Both Groups of Cases*

	1935-1936	1937-1938
Number of cases	11	12
Otitis media	8	8
Mastoiditis (clinical)	3	7
Mastoiditis (at autopsy)	6	0
Mastoidectomy	1	7
Sinusitis	1	2
Origin: outside ear, nose and throat	2	2
Sulfanilamide	0	12
Recoveries	1	10
Deaths	10	2
Autopsies	7	1

X-ray examination showed either acute or chronic inflammation of the mastoid cells in seven patients. Eight mastoidectomies were done on six patients. Four patients were operated on the first day, one of whom was again operated on the fifteenth subsequent day;

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one patient was operated on the third and another on the fourteenth hospital day. The latter patient had been previously operated on at another hospital. All the patients who were operated on recovered.

In this series two patients died (16⅔ per cent) and ten recovered. All of the latter had normal temperatures within eight days after admission. The number of cells in the spinal fluid was usually nearly normal by that time also. Three patients had relapses and therapy had to be started again. The average stay in the hospital was thirty days. One of the two patients who died had a laceration of the head with subsequent massive infection and a fulminating meningitis, while meningitis developed in the other after a subgaleal abscess. Neither infection was adequately drained.

COMMENT

In the twelve cases of streptococcic meningitis reported in this paper and the majority of those described in the literature of the past few years (ninety

TABLE 2.—*Reported Cases of Streptococcic Meningitis Treated with Sulfanilamide and Prontosil*

Author	Outcome: Cases	Outcome: Died	Outcome: Recovered	Treatment	Type of Streptococcus: Alpha	Type of Streptococcus: Beta	Type of Streptococcus: (?)	Sex: Male	Sex: Female	Source of Infection: Ears	Source of Infection: Upper Respiratory Tract	Source of Infection: Elsewhere	Ages
Caussé, Loiseau and Gisselbrecht: Ann. d'oto-laryng., 1936, p. 194	1	0	1	Prontosil, mastoidectomy	..	1	..	1	..	1	..	..	46 years
Arnold, J. G.: Ann. Int. Med. **10**: 1196, 1937	1	0	1	Sulfanilamide, mastoidectomy	..	1	..	..	1	1	..	..	28 years
Schwentker and others [3]	4	1	3	Sulfanilamide, prontosil	..	4	..	3	1	2	1	Cellulitis, scalp	6, 9, 13, 45 years
Arnold, J. G.: Personal communication to P. H. Long [10]	5	0	5	Sulfanilamide	..	5	..	Not reported					
Weinberg, M. H.; Mellon, R. R., and Shinn, L. E.: J. A. M. A. **108**: 1948, 1937	2	0	2	Prontosil, sulfanilamide, mastoidectomy	..	2 (1 questionable)	..	1	1	2	..	..	17, 10 years
Long and Bliss [10]	4	2	2	Prontosil (1), sulfanilamide, transfusion, mastoidectomy (1 case twice)	..	4	..	2	2	4	..	..	7, 9, 47, 3 years
Long and Bliss [10]	9	1	8	Sulfanilamide derivatives; operations not reported	..	9	..	Not reported					
Anderson, E. D.: J. A. M. A. **108**: 1591, 1937	1	0	1	Prontosil, sulfanilamide	..	1	..	1	..	1	..	..	9 years
Trachsler and others [4]	7	3	4	Prontosil (2), transfusion, prontosil and sulfanilamide (5), Foshay's streptococcic serum, antistreptococcus serum, mastoidectomy (6)	1 green died	6 (1 with Staph.)	..	5	2	6	..	1 skull fracture	7, 6, 9, 12, 12, 5, 10 years
Millet, J.: New England J. Med. **217**: 556, 1937	1	0	1	Prontosil, sulfanilamide, mastoidectomy	..	1	..	1	..	1	..	..	13 years
Alpert, G. R., and Forbes, R. P.: Rocky Mountain M. J. **35**: 779, 1938	2 (1 questionable	0	2	Sulfanilamide, mastoidectomy, convalescent serum	..	2	..	..	2	1	1	..	7, 7 years
Friedman, M. D., and Lieberman, L.: Ohio State M. J. **33**: 1322, 1937	1	0	1	Prontosil, sulfanilamide, mastoidectomy	..	1	..	..	1	1	..	..	40 years
Lewy [11]	8	3	5	Prontosil (2), transfusion, prontosil and sulfanilamide (6), mastoidectomy (8)	1 died (mixed A & B)	5 (1 died)	2 (1 died)	4	4	8	..	..	5 months; 4, 7, 9, 9, 11, 49, 50 years
Godwin, D. E.: Laryngoscope **48**: 59, 1938	2	0	2	Prontosil, sulfanilamide	..	2	..	..	2	1	1	..	16, 37 years
Smith, F. W.; Mayer, K. F.; Horst, A. A.; Fowler, R. H., and Layton, W. C.: J. A. M. A. **110**: 887, 1938	1	0	1	Prontosil, transfusion, sulfanilamide, mastoidectomy	..	1 anaerobic	..	..	1	1	..	..	21 years
Silverthorne and Brown [6]	9	4	5	Prontosil, sulfanilamide, mastoidectomy (6)	..	9	..	7	2	8	1	..	12, 19 months; 2, 3, 5, 5, 5, 9, 10 years
Kline [12]	1	0	1	Prontosil, sulfanilamide, mastoidectomy	..	1	..	1	..	1	..	..	15 years
Appelbaum [13]	Probably the same cases as described by Neal												
Vitenson, I., and Konstam, G.: Lancet **1**: 870, 1937	1	0	1	Prontosil, spinal tap, mastoidectomy	..	1	..	1	..	1	..	..	10½ years
Martin, A. T., and Ellenberg, S. L.: Arch. Pediat. **55**: 428, 1938	2	0	2	Prontosil, sulfanilamide, mastoidectomy, transfusion, meningococcus serum	..	2	..	1	1	2	..	..	5½, 7 years
Sacks, P.: Arch. Otolaryng. **28**: 364, 1938	1	0	1	Prontosil, sulfanilamide, mastoidectomy	..	1	..	1	..	1	..	..	6 years
Neal [5]	27	5	21 and 1 under observation	Sulfanilamide, spinal tap, mastoidectomy (16)	..	27	..	10	16	23	3	..	1 yr., 2; 2 yr., 2; 4 yr., 3; 6 yr., 4; 7 yr., 4; 8 yr., 3; 11 yr., 2; 12 yr., 2; 15 yr., 1; 21 yr., 1; 35 yr., 1; 43 yr., 1
Toomey and Kimball	12	2	10	Sulfanilamide, mastoidectomy	..	12	..	4	8	8	2	2	1 yr., 2; 5 yr., 1; 7 yr., 3; 8 yr., 1; 13 yr., 2; 26 yr., 1; 40 yr., 2
Total	102	21	81		2	98	2	43	44	74	9	4	

cases), a total of 102 cases, treatment with sulfanilamide or prontosil or both was given and in eighty-one, or 79.4 per cent, recovery occurred. When table 2 is studied it is seen that three of the reported deaths were caused by alpha, a mixed (alpha and beta) or an unknown type of streptococcus, respectively. The beta hemolytic streptococcus was the sole causative factor in ninety-eight cases; eighteen of these, or 18 per cent, were fatal.

In passing, it may be mentioned that two patients with nonhemolytic streptococcus infection of the meninges treated by us in 1935-1936 died. Of the three patients with comparable disorders seen in 1937-1938 and treated with sulfanilamide, two died and one lived. The latter had otitis media, mastoiditis and meningitis. A mastoidectomy was done and the patient recovered. Several months later a suppurating petrositis and a second attack of meningitis developed. Complete recovery followed treatment and a modified radical Moorhead [1] operation on the petrous bone.

That there is a high mortality with beta streptococcus infections of the meninges is common knowledge. Survival occurred in only two of Tripoli's [2] twenty-four cases, in none of thirty-seven cases treated at Johns Hopkins Hospital,[3] in two of Trachsler's [4] seventy-one reported cases, in twelve of Neal's [5] 238 cases and in one of the twenty-six cases reported by Silverthorne and Brown.[6] Gray,[7] who in 1935 reviewed the literature extensively, reported sixty-six recoveries (including one of his own) since 1901 and estimated the mortality rate to be 97 per cent.

Though the mortality rate is high, recoveries have been reported. Up to December 1937 Appelbaum,[8] Gray,[7] Trachsler and his associates [4] and Litvak and Klughertz [9] had reported 123 recoveries—cases in which various types of therapy were given. Litvak and Klughertz state that in fifteen of the reported 123 cases therapy with sulfanilamide or its derivatives was given. Thus there were 108 cases reported since 1901 in which recovery occurred after various other methods of treatment, in contrast to eighty-one cases in the past few years in which recovery followed the use of the newer chemotherapeutic products.

Two of the patients (the first of Long and Bliss,[10] the fifth of Trachsler and his associates [4]), who died should not be counted as having been treated with sulfanilamide, since they died so soon after admission. The drug was used for less than twelve hours in two of Neal's [5] cases and for less than twenty-four hours in a third. On the other hand, Lewy [11] states that his first patient would probably have recovered even without the small dose of only 5 cc. of prontosil that had been injected. Only one of Kline's [12] patients was treated with sulfanilamide.

In the recent reports, sulfanilamide or prontosil has been given orally, rectally, intramuscularly, intraspinally, subcutaneously and intravenously. Neal [5] reported the first large series of cases in which chemotherapeutic products were not injected intraspinally. We have never injected the drug intraspinally but give it to all patients either orally or subcutaneously.

Some authors stress spinal drainage, frequent lumbar punctures, cisternal or ventricular tappings and the like. In twenty-six of Neal's [5] and Appelbaum's twenty-seven cases (details of one not given) spinal drainage was done. Appelbaum [13] states that it is important to drain the subarachnoid space adequately in all forms of meningitis. Lewy and Hagens [14] report that relief may be obtained by spinal drainage and other methods.

For several years we have not employed frequent drainage in treating either this type of an infection or those infections of the meninges caused by the meningococcus. Lumbar punctures have been done only for diagnosis and later, on the third or fifth hospital day, for prognosis. Only a small amount of spinal fluid (5 cc.) is removed at any one time unless the pressure is extremely high. This has not been found to be the case in most instances. The headaches which accompany acute meningitis have been easily controlled and do not persist much beyond twenty-four hours. Curiously, they are often present when the pressure is found to be decreased. Occasionally it is necessary to do two or three taps and to withdraw small amounts of fluid in order to establish the etiology.

Gray [7] likewise removes only a small quantity of spinal fluid to determine pressure, cell count and the like. He further states that removal of large amounts of spinal fluid at frequent intervals in cases in which the pressure is not increased, with the idea of draining away infectious products, is as reasonable as trying to drain away the blood in septicemia. He states that "it is putting a demand on structures that form the fluid and is liable to lead to their exhaustion and it allows greater influx of bacteria if the initial focus has not been irradicated."

Kubie's [15] method of forcing fluids to produce increased perivascular spinal drainage, as advocated by Retan,[16] is a hospital procedure and not easy to carry out in private practice. We have not found it necessary to adopt such a practice in treating our patients. A good concentration of the drug in the spinal fluid is easily obtained after simple ingestion of the drug. The procedures employed by us have given as good results as those obtained by others who used more involved methods. Our practice has been (1) to give a massive initial dose of the drug followed at once by frequent maintaining doses, (2) to have the patient operated on as soon as possible for removal of the focus of infection and (3) to leave the hydrostatics of the spinal fluid alone unless the pressure is extremely high.

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Sulfanilamide alone may prolong the life of a patient ill with streptococcic meningitis but it will not give complete cure if there is an unattended focus of infection. In a few cases in which the focal point was not recognized immediately, the progress of the disease was held stationary. There was no cure, however, and marked clinical improvement occurred only when mastoid operations were performed by members of the otologic staff.

CONCLUSIONS

Sulfanilamide is the therapy of choice in treating patients with beta hemolytic streptococcus meningitis. However, it is equally important to drain any localized area of infection by proper surgical procedures.

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THE VALUE OF SULFANILAMIDE IN OTOGENOUS INFECTIONS

WITH SPECIAL REFERENCE TO ITS MASKING EFFECT

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The advent of sulfanilamide has resulted in a tremendous advance in the treatment of certain types of otitic infections. The literature is so replete with theoretical, experimental and practical considerations of the value of the drug that further discussion would be redundant. The amazing improvement in prognosis in cases of meningitis is but short of miraculous. It is not our purpose to reiterate the experience of others with remarkable recoveries. Rather are we anxious to illustrate the pitfalls in the injudicious and promiscuous use of sulfanilamide and its misleading effects on the understanding of previously established clinical concepts.

We have been opposed to the indiscriminate administration of sulfanilamide for infections of the upper respiratory tract, many of which run a self-limited course in any event. The free use of the drug, aside from the dangers of toxicity, frequently obscures the clinical picture and often gives rise to a latent course of the disease. Masked forms of mastoiditis and its complications are known to occur. Our point of view regarding the administration of sulfanilamide for minor infections of the upper respiratory tract is necessarily subject to change; however, for the present we use the drug only in otitic complications such as meningitis, sinus thrombosis and brain abscess. Prophylactically we also use it in so-called protective or sympathetic forms of meningitis associated with mastoiditis and its complications. Because of a tendency to obscure the course of infection, our point of view at the present time is that sulfanilamide should be used cautiously, if at all, in acute otitis media. It should not be used in suppurative otitis media. Its use is contraindicated during the course of a suspected mastoiditis before operation and also after operation unless a diagnosis of one of the aforementioned complications has been made.

To be more specific, we feel that, for the present at least, the indications for this form of chemotherapy, from our experience, are as follows: Sulfanilamide should be given in:

Otitis media before suppuration has taken place. We have not had sufficient experience in the use of sulfanilamide in this stage of otitis media. Pediatricians report favorable results in such cases. We do know, however, that otitis media of this type commonly proceeds to spontaneous resolution.

Bacterial meningitis (streptococcic or pneumococcic). Occasionally, in extreme cases, intensive administration is given before operation (from twenty-four to thirty-six hours) and then postoperatively.

Sympathetic meningitis secondary to an extradural abscess, brain abscess, labyrinthitis and so on. Removal of the otitic focus is imperative.

Lateral sinus thrombosis as soon as the diagnosis has been established, followed by thorough operative intervention. It should be continued during the postoperative period. The drug is especially useful in those instances of a continued otitic sepsis even though a thorough operative procedure has previously been performed. In such patients a phlebitis of various venous radicals tributary to the lateral sinus and inaccessible to surgery may be responsible for the continuation of the sepsis.

Petrositis. Sulfanilamide should not be administered during the period of observation because of the danger of masking the clinical course, thus interfering with the proper management of this condition. Should operation be indicated, it is advisable to give sulfanilamide promptly in the usual manner.

That the indiscriminate use of sulfanilamide may result in masked forms of middle ear or mastoid infections and their complications has received but scant reference in the literature. We have observed the tendency of sulfanilamide to mask the clinical picture of an otitic infection sufficiently often to warrant drawing attention to this very important fact. A striking example of latency due to the administration of sulfanilamide was recently reported by Smith and Coon.[1] These writers state that it is possible that a moderate dose of sulfanilamide will partially control meningitis so that it will present a different clinical picture from the one with which we are familiar. During the course of an acute middle ear suppuration their patient, a 4 year old child, had been receiving moderate doses of sulfanilamide. Following a mastoidectomy a clinical picture of sepsis presented itself; i. e., the patient had a spiking temperature course between 100 F. and 104 F., for which no other cause could be assigned despite negative blood cultures. A Tobey-Ayer spinal test was done for the purpose of confirming a strong suspicion of the presence of a lateral sinus thrombosis, but, to the astonishment of those present, the spinal fluid was cloudy, showed a high cell count and on culture grew out Streptococcus haemolyticus. The patient had been euphoric throughout and symptom free. The mastoid was revised and intensive sulfanilamide therapy was then given, followed by recovery.

Otologists for a long time have been familiar with the clinical course of an otitic infection due to Pneumococcus type III. The characteristic insidious clinical pictures that infections due to this organism produce are almost identical with those resulting in some cases from the use of sulfanilamide during the course of acute otitis media. There is the same freedom from pain; mastoid tenderness, which may be present at first, soon lessens or disappears; there may be an apparent improvement of the middle ear infection as indicated by diminution or absence of discharge, but on further examination one notes the appearance of an unresolved middle ear; that is, a thickened drum with absence of

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1. Smith, H. B., and Coon, E. H.: Meningitis Due to a Hemolytic Streptococcus, Arch. Otolaryng. **26**: 56 (July) 1937.

landmarks. Resolution of the middle ear may be much delayed, or a recurrence of signs of a middle ear infection with evidence now of mastoid involvement or an otitic complication may rather abruptly follow a longer or shorter period of latency. Otitic complications run an asymptomatic or atypical course, as pointed out in a number of cases that we have reported.

We would suggest to those who are of the opinion that sulfanilamide should be given from the very onset of otitis media that these patients be carefully observed over an extended period despite an apparent improvement in the ear picture and the absence of symptoms; furthermore, as a therapeutic test we would advise the discontinuance of the drug for a few days during the period of observation to note whether a recrudescence of signs or symptoms of postauricular infection occurs. We have made the latter observation in a number of instances in which the drug had been given for a considerable time.

It is not our purpose in the slightest degree to minimize the remarkable effects of this drug in the conditions previously mentioned. We hope only to convey to those who permit untempered enthusiasm for the indiscriminate use of the drug our experience in the recognition of distortion of known entities by sulfanilamide. Conditions that normally run a self-limited course and have a small percentage of complications are subjected to treatment by a drug whose intrinsic potential danger may be greater than that of the disease.

Our experience shows that sulfanilamide used in the presence of a suppurative focus is not as effectual as when used after the focus has been eradicated. This is especially noted in the reports of various observers in the treatment of meningitis. This form of therapy is ineffective if the original focus is not removed. While sulfanilamide will clear body fluids infected by streptococci, its action is apparently less effective on streptococci located in an active bone lesion.

We have demonstrated that sulfanilamide will only partially control suppurative disease and frequently alters the usual clinical picture and tends to prolong its course if proper surgical measures are not employed.

In summing up our point of view regarding the indications for the use of sulfanilamide, we would say that it is inadvisable to give the drug during the period of observation of a patient for suspected mastoiditis, sinus thrombosis, petrositis and the like because of the risk of masking the clinical picture and thus interfering with the diagnosis and proper surgical indications. In the presence of an impending otitic meningitis from whatever cause, the drug should be given immediately. In a case of otitis media before suppuration has taken place, it may be cautiously given. The patient, however, must be under careful observation for a considerable period following its discontinuance.

The following cases illustrate some of our views regarding the administration of sulfanilamide with particular reference to the question of its masking effect:

REPORT OF CASES

CASE 1.—B. B., aged 7 years, during the course of an infection of the upper respiratory tract, had an influenzal otitis media. Two days later a spontaneous rupture of the drum occurred. The patient's temperature ranged between 100 and 101 F. for a few days and the discharge of the middle ear, thin in character, became quite profuse. Sulfanilamide 40 grains (2.6 Gm.) daily was started one week from the onset of the otitis and was continued for six days. The discharge from the middle ear soon stopped and beginning resolution was noted. The temperature returned to normal and the patient's general condition was excellent. It was decided to discontinue sulfanilamide because of the knowledge of a possible masking effect of the drug. Thirty-six hours after sulfanilamide was stopped the middle ear began to discharge profusely and the discharge was thicker than it had been at any time; the drum now had a "boggy" appearance. Increasing mastoid tenderness was elicited and the patient had spontaneous aural pain. The temperature ranged between 99 and 100 F. When the patient had been observed for forty-eight hours, during which the local manifestations increased in severity, it was decided that a mastoidectomy was indicated. Operation disclosed free pus and granulations with areas of softening throughout an usually large mastoid. Hemolytic streptococci were cultured from the mastoid.

A latent or quiescent period during the administration of the drug is shown by this case, which illustrates the importance of careful observation of patients who are given sulfanilamide during the course of otitis media and the diagnostic value of withdrawal of the drug to determine whether the apparent improvement is only a masking effect of the drug.

CASE 2.—B. S., a boy aged 7 years, complained of bilateral acute otitis media March 11 and was given 80 grains (5.3 Gm.) of sulfanilamide by his family physician. A rash developed and the drug was stopped. Suppuration of the middle ear resolved entirely in two weeks. Four weeks later, that is, six weeks from the onset of the otitis, Dr. Morley T. Smith of New Rochelle was consulted. At this time the patient had a temperature of 102 F. and had but little pain in the ear. On examination Dr. Smith reported that the left drum was bulging with very little discharge from an anterior perforation. Culture of the middle ear discharge following paracentesis disclosed a Pneumococcus type III infection. Two days later he was admitted to the New Rochelle Hospital with a temperature of 103 F. and complaining of hemicranial pain. The mastoid was tender; x-ray examination of the left mastoid showed evidence of a destructive process. In conversation over the telephone Dr. Smith reported to one of us (J. L. M.) the finding of an extremely diseased mastoid with a large perisinal abscess (perforated) and a suppurative sinus thrombophlebitis. The sinus was obliterated; there was no bleeding from the jugular bulb. After consultation three days later Dr. Smith decided to ligate the jugular vein. Following this the temperature returned to normal and the patient experienced an uneventful recovery.

Case 2 illustrates the masking effect of sulfanilamide on the course of mastoiditis which had advanced so that there was present a sinus thrombophlebitis recognized only at operation.

CASE 3.—D. Y., with a history of pain in the left ear followed one week later by a myringotomy, with Streptococcus haemolyticus obtained from the ear, had a thin pulsating discharge which continued for the next three weeks. Hearing was impaired and the nasal sinuses were clear. The patient was given 10 grains (0.65 Gm.) of sulfanilamide every four hours. Twenty-two days after the onset of the infection nystagmus developed to the right and left, more marked to the left. This continued unabated, associated with supra-orbital headache. The middle ear showed evidence of resolution up to the day before operation, at which time the ear drum became full and the middle ear began to discharge. On pressure over the mastoid, the patient complained of slight soreness but no actual pain. The sulfanilamide was stopped.

A left mastoidectomy was performed and there was marked destruction of the mastoid; the dura was covered with fine granulations. The possibility of petrositis was entertained because of nocturnal pain, slight postauricular tenderness, thick discharge, subfebrile course and nystagmus directed to the diseased ear. The patient is now on her way to apparent recovery.

The clinical picture was masked by sulfanilamide, presenting a low temperature and absence of pain, evidence of resolution of the middle ear without signs of

mastoid involvement. Petrositis was the first indication of an otitic complication without apparent postauricular disease.

A great deal more pathologic change was found in the mastoid than was clinically suspected.

In the early stages, postauricular tenderness was marked. Following the administration of sulfanilamide, tenderness was definitely absent although there were now evidences of petrositis.

CASE 4.—T. A., aged 10 years, had scarlet fever followed by acute otitis media for which a myringotomy was performed. The ear drained continuously and profusely. The mastoid was not tender. The patient had been given sulfanilamide for thirty days, about 20 to 30 grains (1.3 to 2 Gm.) a day with no cessation of the aural discharge. For one month there was no headache or postauricular pain.

When first seen, the child's temperature was 99.5 F.; the patient was comfortable. There had been a complaint of a vague temporal headache one day before. There was slight postauricular tenderness and a profuse discharge. The sulfanilamide was stopped and the next day the temperature rose to 102 F. The child became restless and headache became marked. Postauricular tenderness was definitely increased.

A simple mastoidectomy revealed extensive disease everywhere in the mastoid with complete destruction of the zygoma and tip. Culture at operation revealed beta Streptococcus haemolyticus.

Sulfanilamide was given early in this case of acute otitis media. There was a definite progression to coalescent mastoiditis despite the use of the drug and absence of headache, fever and other clinical evidence despite marked destruction of the mastoid.

Twenty-four hours after the discontinuance of sulfanilamide there was a reappearance of fever, headache and postauricular tenderness when the masking effect of the drug was removed.

The ineffectuality of the drug in the presence of a suppurative focus and its capacity to attenuate the course of disease without preventing its progression are shown.

CASE 5.—I. C., a child aged 5 years, white, complained of pain in the left ear two days before admission following cough and fever for ten days. On examination the child was acutely ill. The right ear drum was normal and the left was full, red and covered with hemorrhagic blebs and a thin pulsating discharge. Signs of bronchopneumonia were present. The child was given sulfanilamide with onset of the otitis.

Two days after admission the temperature rose to 105 F., the child became irritable and there were meager clinical signs suggestive of meningeal irritation. Lumbar puncture showed an increase of pressure with cloudy fluid containing 230 cells per cubic centimeter, with 92 per cent polymorphonuclear cells. Subsequently fluid was reported to contain beta Streptococcus haemolyticus, as did the culture from the middle ear. Blood culture was sterile.

The child was given sulfanilamide at four hour intervals day and night, 120 grains (8 Gm.) the first twenty-four hours, then reduced to 90 grains (6 Gm.) a day. The concentration in the blood was kept at from 8 to 10 mg. per hundred cubic centimeters. Fever precipitously subsided and the child was comfortable during the next ten days despite the persistence of meningitis as indicated only by examination of the spinal fluid. Within forty-eight hours after the administration of larger doses of sulfanilamide (90 grains a day), all clinical evidence of meningitis disappeared except for the changes in the spinal fluid. The high cell count continued for a few days and the increased polymorphonuclear count was soon replaced by lymphocytes until the day before the mastoidectomy, when the spinal fluid showed a count of 12 lymphocytes. Culture of the spinal fluid was positive for Streptococcus haemolyticus on only one occasion. A few days later, however, slight but increasing postauricular tenderness was noted with persistence of moderate aural discharge.

Twelve days after admission and ten days after the onset of meningitis, a simple mastoidectomy was performed. Complete destruction of the mastoid without involvement of the dura or lateral sinus was found.

In this case meningitis developed two days after the onset of acute otitis media. It was clinically controlled by massive doses of sulfanilamide; the child remained comfortable and playful, with a temperature of from 100 to 100.5 F. despite the meningeal activity as indicated only by lumbar puncture.

There was a definite alteration in our clinical concept of mastoiditis under sulfanilamide.

CASE 6.—J. L., a woman aged 22, had an infection of the upper respiratory tract two weeks before admission. Four days before admission pain developed in the left ear, followed by a myringotomy one day later. For two days before admission she had been dizzy; the type of vertigo was not carefully described. Fever ranged between 100 and 102 F.; she had no chills or convulsions but she did have a marked parietal headache.

Ten days after admission, signs of an acute mastoditis developed and a left simple mastoidectomy was done under general anesthesia. The mastoid was very large with no destruction of the intercellular septums. Each cell contained thin pus, which was shown subsequently to be beta Streptococcus haemolyticus. Following operation the patient had a sustained febrile reaction which could not be accounted for by the local condition of the ear. Fifteen days after operation she began to complain of pain over the left eye, and at this time the possibility of suppuration of the petrous pyramid was thought of. Examination of the nose and paranasal sinuses did not reveal anything at this time. Twenty days after the original mastoidectomy the mastoid was revised and the petrous pyramid was investigated. Granulations were removed from the sinus plate and middle fossa plate. No tract was visible in and around the semicircular canal. The squama was removed and the dura of the middle fossa was elevated from the superior surface of the petrous pyramid. The ease with which this was done was due to the fact that a large amount of fluid was removed by spinal tap prior to operation. A large gush of nonodorous thick creamy pus was obtained from a pit about half an inch anterior to the arcuate eminence. A rubber drain was inserted and the wound closed. Culture of this pus showed Streptococcus haemolyticus. The patient was given repeated transfusions. Lumbar puncture five days later, because of headache and some rigidity of the neck, revealed evidence of a meningitis with 4,500 cells, 80 per cent polymorphonuclears, 20 per cent lymphocytes and no organisms on smear. The possibility at this time, one month after the original mastoidectomy, of a brain abscess was considered but no localizing signs were found. Repeated spinal taps were done. The patient was placed on large doses of sulfanilamide, the hemoglobin was watched and the content of sulfanilamide in the blood and spinal fluid was determined at regular intervals.

About forty days after the original operation it was first noticed that an anomia and a few changes in the deep and superficial reflexes had developed. Blood cultures were repeatedly negative. At this time brain abscess, loculated meningitis and otitic hydrocephalus were all considered but no definite diagnosis could be made. Because of the persistence of the changes in the spinal fluid, reinvestigation of the wound was done. The dura was seen to be covered by a thick yellow exudate, and on elevation of the dura of the middle fossa a gush of thick creamy pus again appeared. No loculated pockets were found. Because of the persistence of fever and the persistent changes in the spinal fluid and repeated attacks of vomiting and a transient anomia, eight days after the reexploration of the petrous pyramid an exploratory craniotomy for an abscess of the left temporal lobe was performed. Aspiration in several directions in the temporal lobe failed to show any pus. The dura was incised and it was noted that the brain had a peculiar yellow discoloration, but no pus was found. Following the craniotomy the patient's condition was just about the same until a dressing was done ten days later and the probe fell into a cavity in the temporal lobe. A few ounces of thick pus escaped. After

drainage of this abscess cavity the patient's condition progressively improved, the neurologic condition gradually subsided and, except for the peculiar mental changes, the patient appeared to be getting well. Slowly thereafter the spinal fluid cleared up, her mental state returned to normal, her temperature was flat and patient went on to an uneventful recovery with no sequelae other than some diminution of hearing.

This patient had an acute mastoiditis complicated by a suppurative petrositis, a streptococcic meningitis and an abscess of the left temporal lobe. There was a masked clinical picture of an otitic meningitis from the use of sulfanilamide. On a number of occasions, except for a moderate rise in temperature, the patient was symptom free. Physical signs were absent and yet a spinal tap gave definite evidence of meningitis; i. e., increased cells and streptococci.

Until the otitic focus was adequately dealt with, sulfanilamide only partially controlled the meningitis.

This report illustrates a prolonged course (two and one-half months) of meningitis under sulfanilamide administration.

SUMMARY AND CONCLUSIONS

The use of sulfanilamide has resulted in a genuine advance in the treatment of certain otogenous infections.

Exenteration of the otitic focus is of paramount importance.

Indiscriminate use of the drug may obscure the diagnosis or result in a masked or latent clinical picture of mastoid involvement.

Under sulfanilamide therapy, the usual clinical course of an otitic complication may be modified.

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NOTE ON THE MANAGEMENT OF HYPOPARATHYROIDISM WITH DIHYDROTACHYSTEROL

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The criticism is frequently made that metabolic diseases such as those related to the parathyroid glands require for their successful treatment laboratory facilities beyond the reach of all but a very few. It is my object in this note to point out that this is no longer true as regards hypoparathyroidism.

It is perhaps of interest that in hypoparathyroidism and diabetes mellitus there is quite close parallelism as regards the evolution of therapeutics. In both conditions there was a time when the treatment required a great deal of scientific knowledge and laboratory equipment and was none too satisfactory; now the treatment is both simple and satisfactory. Insulin and especially protamine zinc insulin made the difference with diabetes; dihydrotachysterol with hypoparathyroidism. From an academic point of view it is perhaps too bad that the practitioner no longer needs to master ketogenic-antiketognic ratios or the interesting detailed knowledge on the treatment of hypoparathyroidism so well summarized in the classic paper by Ellsworth.[1] One can go a step further as regards the hypoparathyroid patient: It is no longer even necessary that a blood calcium determination be done.

1. Ellsworth, R.: Diagnosis and Treatment of Parathyroid Underfunction, Internat. Clin. **3**: 27, 1933.

The problem can be very simply stated: All the tetany symptoms of hypoparathyroidism are due to the low level of the calcium of the blood. The goal to be sought is to raise the level of calcium to normal without overdoing the process and obtaining hypercalcemia. Thus all that is needed is an agent to raise the blood calcium level readily to any desired degree and a simple method of gaging this level. Dihydrotachysterol fills the first need and the Sulkowitch test for calcium in the urine the second.

Dihydrotachysterol,[2] like vitamin D, is a photochemical derivative of ergosterol. It was developed by Holz in Berlin for the treatment of hypoparathyroidism. That one can easily raise the calcium of the blood to any desired or even an undesired level with this substance requires no further testimony. The literature was reviewed by Albright, Bloomberg, Drake, and Sulkowitch [3] in a paper which contrasted the action of dihydrotachysterol with that of vitamin D. So much for the therapeutic agent.

Before the means of controlling this therapeutic agent are discussed it will be helpful to list some of the important points in the blood calcium scale. The level of calcium in the serum of a normal person is from 9.5 to 11 mg.; that of a completely parathyroidectomized person from 5 to 7 mg. The normal level of calcium in the serum is above the threshold for the excretion of calcium in the urine; this threshold varies between about 7.5 mg. and 9 mg. Above about 11.5 mg. large amounts of calcium are excreted in the urine and may lead to nephrolithiasis or nephrocalcinosis. At levels of about 16 mg. of serum calcium the danger of sudden death due to hypercalcemia is present.

With these points in mind and with the help of a very simple test (described hereafter) for differentiating urine specimens with no calcium, with a small amount of calicum and with a large amount of calcium, the regulation of the dosage of dihydrotachysterol becomes very easy. The patient with parathyroid tetany, if the diagnosis is correct, should have no calcium in the urine. It should be kept in mind that alkalosis tetany due to hyperventilation is very common and may occur in a patient following an operation on the thyroid. Such a patient will continue to excrete calcium in the urine. Once the diagnosis of parathyroid tetany is made, dihydrotachysterol is administered until the urine tests show moderate amounts of calcium. If large amounts of calcium appear in the urine, the dosage is reduced and the danger of hypercalcemia is avoided.

The Sulkowitch reagent [4] is a solution containing oxalate radicals buffered at such a p_H that when equal amounts of the reagent are added to urine the calcium will almost immediately come down as a fine white precipitate of calcium oxalate. If there is no precipitate there is no calcium, and the serum calcium level is probably from 5 to 7.5 mg. per hundred cubic centimeters. If there is a fine white cloud, there is a moderate amount of calcium and the level of calcium

2. Dihydrotachysterol is distributed in the United States by the Department of Medical Research of the Winthrop Chemical Company. It is marketed in an oily solution, each cubic centimeter containing 5 mg. of dihydrotachysterol. The preparation is administered by mouth.

3. Albright, Fuller; Bloomberg, Esther; Drake, Truman, and Sulkowitch, H. W.: A Comparison of the Effects of A. T. 10 (Dihydrotachysterol) and Vitamin D on Calcium and Phosphorus Metabolism in Hypoparathyroidism, J. Clin. Investigation **17**: 317 (May) 1938.

4. Two and five-tenths Gm. of oxalic acid, 2.5 Gm. of ammonium oxalate and 5 cc. of glacial acetic acid are dissolved in distilled water and made up to a volume of 150 cc. (Barney, J. D., and Sulkowitch, H. W.: Progress in the Management of Urinary Calculi, J. Urol. **37**: 746 [June] 1937).

in the serum is in the satisfactory range. If the precipitate looks like milk, the danger of hypercalcemia is present.

The patient does his own tests and modifies the dose according to the results. I usually prescribe about 3 cc. of dihydrotachysterol a day until calcium appears in the urine and then I drop the dosage to a maintenance level of about 1 cc. from three to five times a week.

This discussion has been slightly oversimplified. There are a few "ifs" and "buts" that must be added. Occasionally a normal person who happens to be on a very low calcium diet will show in a single specimen of urine practically no calcium. Almost any normal person shortly after drinking a large amount of milk will show an excess of calcium in the urine. Since one keeps one's patients with hypoparathyroidism on a high calcium diet, one would expect them always to show hypercalciuria if their levels of serum calcium are normal. It thus turns out that if the dosage is reduced when a large amount of calcium appears in the urine the blood calcium will be kept at a slightly subnormal level. Such is the case. This is probably all the better, since it further guards against hypercalcemia, and slight hypocalcemia is not deleterious.

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THE INHIBITORY EFFECT OF SULFANILAMIDE ON WOUND HEALING

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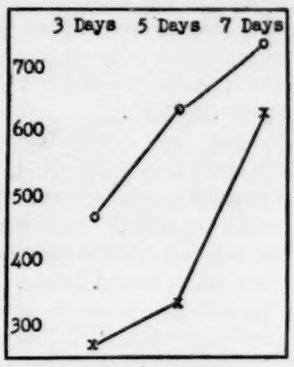
The enthusiasm with which sulfanilamide is being used in the treatment of infections of all kinds has tended to minimize a consideration of the possibility of any harmful effects of the drug. Recently the idea has been expressed by many that it might be used prophylactically before certain operations in which the chance of wound infection may be great. It seemed desirable therefore to determine whether or not this drug has any inhibitory effect on wound healing, especially since antiseptics as a group do have such an effect.

The method used was a modification of the technic of Harvey [1] and those working with him [2] in their experiments on wound healing, in which the tensile strength is used as an indicator of fibroblastic growth. Advantage was taken of their finding that there is a "lag phase" of three or four days before fibroblastic growth reaches a maximum velocity and that, in the first three or four days following the making of the wound, determinations of tensile strength are confused somewhat by the effect of suture material. Accordingly, in this experiment the first observations were made seventy-two hours after operation.

Healthy stock dogs were used. Sulfanilamide (para-amino-benzene-sulfonamide, Winthrop) 3 Gm. daily was given for three days prior to operation. This dose ranged between 0.1 and 0.2 Gm. per kilogram of body weight. The drug was given by mouth in 1.5 Gm. doses twice daily. At operation a 2 cm. incision was made into the fundus of the stomach on the anterior surface. The wound was closed with two layers of 000 plain catgut. A blood sample was taken from the treated dogs for sulfanilamide determination. The dogs were killed three, five and seven days after the operation. Blood specimens were taken at this time, and the tensile strength of the wounds was determined. These determinations were made by removing the stomach, clamping off the pylorus and inserting a cannula into the esophageal end. The cannula was connected to a source of compressed air and to a glass U tube. The pressure within the stomach was measured in millimeters of water, and the velocity of air flow was regulated by hand so that the different-sized stomachs would reach their maximum pressure capacity in approximately ten seconds. The level of pressure at which the edges of the wound separated and air escaped from the stomach was observed and recorded. After satisfactory standardization of the procedure, twenty-eight dogs were used for the experiment, fourteen of these being controls.



Tensile strength. The curve plotted with circles represents the control animals; that designated by crosses represents the dogs which received sulfanilamide.

The method of sulfanilamide determination was that described by Marshall and his associates.[3] Some of the values were rather low, however, as shown in the accompanying table. This is explained by the fact that they were usually obtained from twelve to sixteen hours after the last dose of sulfanilamide, sufficient time having elapsed for an appreciable lowering of the blood concentration by excretion. It is seen that the dogs received the drug in a quantity comparable to that used therapeutically by human beings. After operation the administration of the drug was continued until the animal was killed.

Concentration of Sulfanilamide in the Blood and Tensile Strength

		Blood Sulfanilamide, Mg. per 100 Cc.		Tensile Strength (Mm. H_2O)	Mean Tensile Strength	Controls		
	Dog	At Operation	When Killed			Dog	Tensile Strength	Mean
Three days	1	8.3	17.3	356		5	510	
	2	7.0	8.0	226		6	480	
	3	?	10.0	246		7	520	
	4	6.4	12.0	296		8	440	
	11	4.8	7.5	280	280	9	460	482
Five days	12	?	11.0	310		10	640	
	13	8.7	9.3	340		21	630	
	14	7.0	7.4	360		22	680	
	15	7.4	8.0	280		23	580	
	16	4.5	7.0	410	340	24	720	650
Seven days	17	4.0	12.5	606		25	780	
	18	5.5	5.4	580		26	710	
	19	5.5	7.2	640		27	820	
	20	3.7	8.2	726	638	28	690*	750

* The only instance in which the wound of the treated animal showed greater tensile strength.

From the table of results and the chart, one can see that there is a noticeable difference in the tensile strength of the wounds of the treated and the untreated dogs. Despite the rather crude method of determina-

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1. Harvey, Samuel C.: The Velocity of the Growth of Fibroblasts in the Healing Wound, Arch. Surg. **18**: 1227-1240 (part 2) 1929.

2. Howes, Edward L.; Socy, Joseph W., and Harvey, Samuel C.: The Healing of Wounds as Determined by Their Tensile Strength, J. A. M. A. **92**: 42 (Jan. 5) 1929.

3. Marshall, E. K., Jr.; Kendall, Emerson, Jr., and Cutting, W. C.: Para-Aminobenzenesulfonamide Absorption and Excretion: Method of Determination in Urine and Blood, J. A. M. A. **108**: 953-956 (March 20) 1937.

tion and the obvious chance for error, this difference is so consistent throughout as to be unquestionable. It can be seen from the figures that fibroblastic growth is inhibited and does not reach its maximum velocity until after the fifth day. By the seventh day, however, the wounds of dogs treated with sulfanilamide were but slightly below those of untreated dogs in tensile strength. From the curves obtained one would judge that had the experiment been carried further a point would have been reached at which the wounds would have been of equal strength.

CONCLUSION

Sulfanilamide, given to dogs in doses comparable to the therapeutic doses used by human beings, has an inhibiting effect on the healing of uninfected incised wounds, as determined by the tensile strength.

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SULFAPYRIDINE AND PNEUMONIA

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Since the advent of sulfapyridine we have treated three patients with pneumonia with this drug together with other measures and hope that what we have to offer will be of some benefit to others in the treatment of that most dreaded disease.

One patient, a child of 2 years, responded satisfactorily to sulfapyridine without other drastic therapy. The two other patients, both women, became extremely nauseated and vomited after the first dose. The temperature of each was falling but something had to be done to relieve the gastric distress. As continuous operation of the oxygen tent is expensive for the patient, we put them under the tent a half hour before sulfapyridine was administered and kept them there for a half hour after medication, and there was no more nausea or vomiting. The oxygen therapy was continued until the temperature became normal, at which time the dose of sulfapyridine was cut.

The two adults were given two doses of 2 Gm. (30.8 grains) each four hours apart, then 1 Gm. (15.4 grains) every four hours until the temperature became normal and thereafter 0.5 Gm. (7.7 grains) every four hours for two days. The leukocyte count, taken daily, was lowered as the temperature fell.

Another interesting feature of this type of treatment is the fact that digitalis was not used for any of the three patients, whereas as a routine we had been using it for all patients with pneumonia. The time of hospitalization was markedly decreased.

REPORT OF CASES

CASE 1.—Miss M. H., aged 34, admitted to St. Ann's Hospital April 15, having had influenza for one week without improvement, had a temperature of 102 F., a pulse rate of 108 and a respiratory rate of 24. There was considerable cough. Examination of the chest gave negative results.

April 16 examination of the chest, with roentgenograms, showed bronchopneumonia of the left lung. Sulfapyridine 2 Gm. (30.8 grains) was given at 1 p. m., and a mustard plaster was applied. The leukocyte count was 20,200, the temperature 104.6 F., the pulse rate 120 and the respiratory rate 28. The patient was very cyanotic and restless. Morphine sulfate 0.01 Gm. (⅙ grain) was administered by hypodermic. The patient became very nauseated and vomited three hours after the first dose of sulfapyridine. At 5:20 p. m. sulfapyridine 2 Gm. was given. The patient vomited at 6:30 p. m. The sputum, which was rusty, was typed but did not contain pneumococci of types I or II, for which we had specific serum; therefore no serum was given.

April 17 at 8 a. m. the temperature was 97.8 F., the pulse rate 94 and the respiratory rate 20. As the patient was vomiting almost continuously, the use of sulfapyridine was discontinued and dilaudid was used instead of morphine for the restlessness. The sputum was clear in color. At 7 p. m. the leukocyte count was 19,550. The temperature began to rise, and sulfapyridine tablets were crushed and given in peppermint water, but the patient immediately vomited.

April 18 at 8 a. m. the temperature was 102.2 F., the pulse rate 112, the respiratory rate 24 and the leukocyte count 16,400. The patient was very cyanotic and the sputum rusty. She was put under an oxygen tent and the administration of sulfapyridine 1 Gm. started. She did not become nauseated or vomit again.

April 19 at 8:30 p. m. the temperature was 98.6 F., the pulse rate 84, the respiratory rate 20, the leukocyte count 15,300 and the erythrocyte count 4,310,000.

The oxygen tent was used for only one-half hour before and after medication, and its use was completely discontinued on the morning of April 20. The administration of sulfapyridine was discontinued April 21. The leukocyte count was then 12,650. The patient had had no fever for two days. Daily examinations of the urine showed a 1 plus reaction for albumin.

April 24 the patient was allowed out of bed, and April 27 she was discharged from the hospital.

The time of hospitalization was twelve days.

CASE 2.—J. E. Jr., aged 2 years, admitted to St. Ann's Hospital April 19, had a rectal temperature of 102 F. at 8 a. m. A diagnosis of bronchopneumonia of the right lung was confirmed by x-ray examination. Sulfapyridine was given, 0.5 Gm. (7.7 grains) in the first dose and 0.25 Gm. (3.9 grains) every four hours thereafter. The temperature was normal April 21 at 6 a. m., at which time the dose of sulfapyridine was reduced to 0.13 Gm. (2 grains) every four hours. This dose was administered until April 25, when the patient was discharged from the hospital.

The oxygen tent was not necessary for this patient. No blood counts or urinalyses were done.

The time of hospitalization was six days.

CASE 3.—Mrs. P. E., aged 20, admitted to St. Ann's Hospital April 27, having been sick for four days at home with "the flu," had a temperature of 104 F., a pulse rate of 120 and a respiratory rate of 32. She was cyanotic and coughing. A diagnosis of lobar pneumonia involving two thirds of the left lung was made and confirmed by x-ray examination. Sulfapyridine 2 Gm. and dilaudid for rest were given at 8:30 p. m. The patient became nauseated and vomited two hours later.

April 28 at 12:30 a. m. sulfapyridine 2 Gm. was given. The patient vomited at 3:30 a. m. Sulfapyridine 1 Gm. was given at 4:30 and 8:30 a. m., but the patient was nauseated and vomited almost constantly. The oxygen tent was therefore used for one-half hour before and after medication. From 8:30 a. m. April 28 the patient was completely free from nausea and vomiting. The leukocyte count was 18,550, the temperature 102 F., the pulse rate 116 and the respiratory rate 28.

On the morning of April 29 the leukocyte count was 25,800, the temperature 101 F., the pulse rate 120 and the respiratory rate 26, but by 4:30 p. m. the temperature was normal, the pulse rate 90 and the respiratory rate 22. The use of the oxygen tent was discontinued and the dose of sulfapyridine cut to 0.5 Gm. every four hours.

April 30 the leukocyte count was 12,050 and the patient was feeling very well. The use of sulfapyridine was discontinued May 1. The patient was allowed out of bed May 2 and discharged from the hospital May 3. Daily urinalyses showed a 1 plus reaction for albumin.

The time of hospitalization was six days.

SUMMARY AND CONCLUSIONS

The number of cases reported is very small, but the results were so striking that other physicians may derive benefit from the use of oxygen with sulfapyridine.

The patients were placed in the oxygen tent for one-half hour before and after medication, with complete relief of nausea and vomiting and marked alleviation of the cyanosis.

No experimental work or blood chemistry determinations, such as testing the carbon dioxide–combining power, was done to ascertain the reason for the relief of nausea and vomiting following the use of the oxygen tent. Undoubtedly the sulfapyridine produced the nausea and vomiting.

The time of hospitalization was greatly reduced.

No complications developed in any of the three cases.

The oxygen tent might well be used with every dose of sulfapyridine until the temperature becomes normal.

BLOOD SUGAR VERSUS URINE SUGAR

AS OBSERVED IN PATIENTS TREATED WITH PROTAMINE ZINC INSULIN AND WITH ORDINARY INSULIN

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PHILADELPHIA

(Concluded from 2508)

SUMMARY OF OBSERVATIONS

1. None of the patients in table 1 at any time during examination of the urine within the three hour period after breakfast excreted dextrose in spite of the increased blood sugar. In many of the patients the blood sugar was above the normal level after meals. Patients on protamine and ordinary insulin maintained higher blood sugar levels postprandially without glycosuria than those on either form of insulin alone, or those without insulin. Two of the patients without insulin maintained increased blood sugar levels above normal without glycosuria.

2. Many patients in table 2 averaging elevated blood sugar levels above normal after meals excreted less dextrose in the urine than many of those patients averaging lower elevations of blood sugar but still above normal. This was more common in patients on protamine and ordinary insulin. These observations also occurred in many of the patients in tables 3 and 4.

An interesting observation made in the individual blood sugar examinations of the patients at the end of the first and second hour was the marked fluctuations in the blood sugar levels not only in different patients but also in the same patient on different days of our examination. These bore no corresponding relationship to the amount of glycosuria and could not have been detected by examinations of sugar in the urine.

Thus, during an individual study of case 56 in table 2, the patient, on protamine zinc insulin alone, in one of our examinations at the end of the first and second hour had a blood sugar level of respectively 162 mg. and 172 mg. per hundred cubic centimeters with 0.7 Gm. of dextrose excreted in the urine. In the same patient a few days later, at the end of the first and second hour, it was respectively 284 mg. and 370 mg. with 0.6 Gm. of dextrose in the urine. In case 15 in table 2 during a similar study, but on ordinary insulin alone, at the end of the first and second hour it was 320 mg. and 234 mg. respectively with 0.7 Gm. of dextrose in the urine; a few days later it was 296 mg. and 212 mg. respectively with no spill or excretion of dextrose in the urine. Similar results occurred frequently throughout our studies.

3. It is also interesting to note that we have observed on rare occasions low blood sugar levels after meals with urine positive for dextrose. An example is the case of a man aged 22 on protamine and ordinary insulin whose postprandial (two hours after breakfast) blood sugar was 66 mg. per hundred cubic centimeters with 0.5 Gm. spilled in the urine.

We have also observed in our wards low postprandial (two hours after breakfast) blood sugars, not infrequently at a hypoglycemia level, with no apparent symptom. This is exemplified in a girl aged 14 years, being observed on protamine and ordinary insulin, whose blood sugar was 37 mg. per hundred cubic centimeters and who was symptom free with a negative urine for dextrose, probably because she was inactive and resting in bed. On another occasion with less insulin she had mild shock symptoms, such as an increased sense of warmth and slight nervousness, with a blood sugar two hours after breakfast of 55 mg. per hundred cubic centimeters.

4. We have also observed patients (table 3) with variable average blood sugar levels who excreted approximately the same amount of dextrose in the urine. These variable blood sugar levels averaged from 166 to 330 mg. per hundred cubic centimeters at the end of the first hour after breakfast with an approximate average excretion of dextrose in the urine between 1.4 and 1.9 Gm. These results occurred more frequently in the patients on protamine and ordinary insulin, although not infrequently in those on ordinary insulin alone.

5. We have also observed patients (table 5) whose individual blood sugar elevations above normal in the first and second hour after breakfast varied markedly with little or no change in the dose of insulin. These patients also showed at different intervals extreme variations in the amount of excretion of dextrose in the urine, as from 0 to 3.7 Gm., the excretion bearing no relationship to the fluctuations of the blood sugar levels. Such observations were more common in the patients on protamine and ordinary insulin than in those on ordinary insulin alone. Thus in case 12 of table 5 (on protamine and ordinary insulin) the blood sugar at the end of the first and second hour was respectively 280 mg. and 268 mg. per hundred cubic centimeters with no excretion of dextrose in the urine; on another day it was 230 mg. and 138 mg. per hundred cubic centimeters with 3.7 Gm. of dextrose excreted in the urine; still another day it was 410 mg. and 338 mg. with 1 Gm. of dextrose spilled.

We have also observed patients on protamine and ordinary insulin (case 29, table 4) whose averaged blood sugar at the end of the first and second hour was 219 mg. and 169 mg. per hundred cubic centimeters respectively, with an average excretion of 14.07 Gm. of dextrose in the urine. In case 54 (table 4), on ordinary insulin alone, the average blood sugar level was respectively 289 mg. and 280 mg. per hundred cubic centimeters, with an average excretion of 23 Gm. in the urine. In case 12 (table 5), on protamine and ordinary insulin the blood sugar level at the end of one and two hours was 410 mg. and 338 mg. respectively, with excretion of 1 Gm. of dextrose, but a few days previously the blood sugar was 280 mg. and 268 mg. per hundred cubic centimeters with no excretion of sugar.

6. In the twenty-four hour urine study we observed patients with blood sugar levels elevated above normal, one and two hours after breakfast, but with no sugar in the urine. These observations were made not infrequently in the large group of diabetic patients who were on both forms of insulin (protamine and ordinary). The highest postprandial blood sugar levels with a negative twenty-four hour urine was observed in the patients on ordinary insulin alone; lower levels with negative twenty-four hour urine were observed in the patients on protamine and ordinary insulin. At not uncommon intervals the latter level was at a hypoglycemic point without symptoms of insulin shock.

7. On rare occasions patients on protamine and ordinary insulin were observed with a low postprandial blood sugar, 66 mg. per hundred cubic centimeters, but with sugar in the urine. In these cases, if the sugar in the urine alone was the determining factor for adjusting the insulin dose, the patient would probably have received an increased dose and be subjected to serious consequences. An interesting finding was that many patients on the protamine and ordinary insulin maintained postprandial blood sugar levels above the normal level but the urine was normal within three hours after breakfast and in the twenty-four hour urine study.

INTERPRETATION OF OBSERVATIONS

In reviewing the literature we find it replete with controversy as to the significance of sugar in the urine and the relation of such sugar to glycemia. Our own observations confirm those of many of the references given that disturbance in the blood sugar concentration is the first apparent manifestation of the disturbances to be corrected in diabetes. The urine sugar, whose source is the blood sugar, not uncommonly is an unstable quantity bearing no corresponding relationship to the blood sugar level or concentration. Probably this absence of definite quantitative relationship between blood sugar and urine sugar in diabetic patients is due to disturbances affecting kidney functions. Thus:

(*a*) Kidney function may be depressed or interfered with by "extrarenal" disorders, such as heart disease, severe general anemia, hypertrophied prostate, cystitis [21] and the like. Or it may be depressed or interfered with by "intrarenal" factors, such as variation in the degree of concentration of dextrose in the plasma, or the volume of the glomerular filtrate or of renal activity [3] affecting the filtration-reabsorption process. If only a relatively few glomerulotubular units are active, Sherrill and MacKay [3] feel that it is reasonable to suppose that a much higher concentration of dextrose in the plasma would be required to cause sugar to appear in the urine than if the kidneys were fully active. On the other hand they feel that, with all the renal elements functioning, diuresis might so reduce the reabsorption of dextrose that a concentration of dextrose in the plasma considerably lower than usual might be reached before sugar-free urine would be formed. Page and Corcoran [5] are under the apprehension that the only true "extrarenal" disturbance which might alter the excretion of dextrose is a decrease in glomerular filtration to the point at which little filtrate is formed—a situation not infrequent in diabetic coma with vasomotor failure, in which dextrose may disappear from the urine. This state they say passes rapidly into one in which no glomerular filtrate is formed and the patient is anuric. Gopfert [32] believes that in the course of diabetic coma there is a disorder in the renal activity which is responsible for many of the complications that occur. He is also of the opinion that probably this disorder is in conjunction with circulatory disturbances and metabolic anomalies that work together and, depending on the predominance of the one or the other, cause different symptoms to predominate.

(*b*) Blatherwick and Medlar [33] have shown through animal experiments that functional impairment of the kidney may exist for some time before histologic changes indicative of nephritis become apparent. They suggested that the initial impairment of the kidney may be a change in the functional activity of the glomerulus. The injurious factor responsible for this either may exist in the diet or may be produced during metabolism. The consequences of this observation become more evident when one considers that in view of the increasing incidence of premature arteriosclerosis shared generally by the body, including the kidneys, the disturbed diabetic metabolism is not completely corrected by insulin and diet. Local infections, however trivial or insignificant they may be to the nondiabetic person, must be guarded with the greatest fear by the diabetic patient against the possibility of their becoming generalized and bringing about a dangerous state.

From clinical data we infer that the apparently normal metabolism in diabetes in the absence of complications is in reality abnormal. Thus in the presence of infection it behaves in a manner somewhat similar to the metabolism of an untreated diabetic person [34] in spite of the insulin and diet. Hence why cannot the abnormal metabolism in diabetes, in spite of the apparent normality, be a factor responsible for the alteration of kidney function in such a manner that the quantitative sugar excretion bears no relationship to the level of blood sugar as shown by our studies? This also becomes more apparent when one realizes the large number of cases presenting concomitant pathologic changes of the kidney which form a part of the generalized arteriosclerosis in diabetes as revealed at postmortem examination. Warren's [34] incidence of arteriosclerosis in 300 fatal cases of diabetes showed forty-nine with a slight degree of either arteriosclerotic or chronic progressive (arteriosclerotic) nephritis, forty-seven with moderate pathologic changes and only eleven with marked pathologic changes. Stewart and McIntosh's [35] studies on renal function revealed that nineteen of twenty patients with arteriosclerotic or hypertensive heart disease had impaired renal function. Warren [34] emphasizes the fact that the kidneys of those in the older age groups are frequently already impaired when they are needed to effect the maintenance of acid-base equilibrium.

(*c*) Still one may have functional impairment in the absence of pathologic changes. Experiments in animals have shown that functional impairment of the kidneys may exist for some time before histologic changes become apparent.[33] This functional disturbance without histologic or pathologic changes probably may be compared to the pancreas, in which there is a frequent absence of demonstrable pathologic changes responsible for the diabetic condition or functional disorder of the insulin mechanism.

32. Gopfert, E.: Increase in Rest Nitrogen During Diabetic Coma, Klin. Wchnschr. **16**: 1369-1408 (Oct. 2) 1937.

33. Blatherwick, N. R., and Medlar, E. M.: Chronic Nephritis in Rats Fed High Protein Diets, Arch. Int. Med. **59**: 572 (April) 1937.

34. Warren, Shields: The Pathology of Diabetes Mellitus, Philadelphia, Lea & Febiger, 1930.

35. Stewart, H. J., and McIntosh, J. F.: The Function of the Kidneys in Patients Suffering from Cardiac Disease Without Signs of Heart Failure, J. Clin. Investigation **6**: 325 (Oct.) 1928.

Warren [34] states that practically any lesion found in the pancreas of the diabetic patient involving either the island tissue or the acinar tissue or both can be duplicated in the pancreas of nondiabetic persons. These observations are noteworthy when one realizes that the kidneys are functioning in a more or less constant environment of disturbed carbohydrate metabolism, a factor, probably, in spite of its apparent normality, in bringing about renal functional disturbances as related to renal threshold and with the problem of the relationship of glycosuria to glycemia with or without definite pathologic changes. Elliot and Nuzum [36] believe that one cannot separate the kidney from a constantly changing circulatory environment on which its functional response must in great measure depend. Epstein [37] says that there is no a priori reason to believe that the utilization of sugar in the kidney differs in any way from that of any other organ or tissue. He says that there are frequently encountered cases of diabetes which show no evidence of renal disease, in which the glycosuria disappears spontaneously or as the result of treatment but in which a hyperglycemia persists.

(*d*) Renal functional tests are of little or no aid in revealing true functional disorders of the kidney or the extent of pathologic changes. Levinson and MacFate [21] feel that such tests as the phenolsulfonphthalein or the urea clearance simply measure the function of the kidney in respect to that specific substance and not the extent of anatomic changes in the kidney and that they are not an absolute criterion as to how the kidneys will excrete the normal or abnormal products of metabolism. Elliot and Nuzum [36] feel that the more sensitive the test of function, the more it may be influenced by factors—changing vascular tone and decreased cardiac reserve—and therefore the more difficult is the interpretation in the terms of renal pathologic conditions. Statistical conclusions regarding the incidence of faulty renal function in patients with hypertension, they say, will vary so greatly with the tests used and with the manner of their interpretation as to mean little or nothing.

Patients on protamine zinc insulin therapy may have sugar-free urine in the morning before breakfast and feel fine but may have a low blood sugar, even to a level of hypoglycemia, without symptoms. This may also occur between meals if the interval is prolonged, as in a case we observed of a patient, aged 59 years, on protamine and ordinary insulin, with a postprandial blood sugar (two hours after breakfast) of 37 mg. per hundred cubic centimeters and also of a girl, aged 15 years, with a blood sugar (two hours after breakfast) of 25 mg. per hundred cubic centimeters without symptoms. This interval with the blood sugar at the level of hypoglycemia, however mild it might appear to a diabetic patient, may cause damage to the cardiovascular and neurologic systems. Kepler and Moersch [38] claim that there occur not only transitory changes in the nervous system but also irreversible changes of a permanent character, possibly as the result of frequent and severe hypoglycemic reactions.

If a hypoglycemic state should occur during sleep when the patient is at complete rest, there would be little likelihood of warning symptoms—a dangerous state of affairs. Wilder [39] records several instances of patients awakening in the morning with sore, stiffened muscles, a bitten tongue and attacks with convulsions. He speaks of being informed of one death following protamine zinc insulin and fears that others will follow unless great pains are taken to impress patients with the importance of heeding early symptoms and combating them with carbohydrate. Wilder cites Bollman's experiments with animals that died from fatal convulsions caused by protamine zinc insulin in which he found multiple petechial hemorrhages scattered throughout the brain. Sherrill and MacKay's [40] observations on animals that died of protamine zinc insulin shock found grossly no particular abnormality of the brain. In reporting the untoward effects of hypoglycemia, they compare the damage to that due to anoxemia.

(*e*) Another dangerous possibility, if the procedure is restricted to examination of the urine, is that one may confuse the not infrequent symptomless hypoglycemic state caused by protamine and ordinary insulin therapy for hyperglycemia, especially if the urine is positive. If the patient excretes sugar in the urine, as in the case of a young man with a postprandial blood sugar (two hours after breakfast) of 66 mg. per hundred cubic centimeters, it would add to the difficulty of making the correct diagnosis. In such a state, if the patient had symptoms of discomfort or mild signs of insulin reaction, his condition might be diagnosed as showing an increased blood sugar with the result that the physician might be tempted to increase the insulin dose, thereby producing serious consequences. Wauchope [41] reported a fatal hypoglycemia due to mistaken diagnosis when more ordinary insulin was prescribed. Leyton,[42] in reporting a case in which glycosuria occurred in spite of the hypoglycemia, stresses the practical importance of this, because if one were to cease giving sugar when sugar appeared in the urine the patient would die from hypoglycemia. Jackson and Boyd [43] speak of a patient who died at home under circumstances which strongly indicate that death was attributed to hypoglycemia brought on by protamine zinc insulin. Lindsay and his associates [44] reported a fatal case due to hypoglycemia as a result of protamine zinc insulin. Jonas [45] also reports a case of fatal hypoglycemia due to insulin after it had been discontinued eleven days. Joslin and his co-workers' [46] comment on a case of fatal hypoglycemia mistaken for diabetic coma was that if the urine had been obtained when the patient was admitted to the hospital it would not have solved the differential diagnosis between coma and hypoglycemia, because often the first specimen of urine voided by the hypoglycemic patient contains sugar, having been secreted perhaps hours earlier by the kidneys. Joslin,[47] in describing four deaths due to hypo-

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44. Lindsay, J. W.; Rice, E. C.; Selinger, M. A., and Mish, K. H.: Protamine Insulin as a Contributing Factor in the Death of a Diabetic Patient with Cerebral Arteriosclerosis, Ann. Int. Med. **10**: 1892 (June) 1937.
45. Jonas, Leon: Hypoglycemia, M. Clin. North America **8**: 949 (Nov.) 1924.
46. Joslin, E. P.; Root, H. F.; White, Priscilla; Marble, Alexander, and Joslin, H. P.: Diabetic Coma, Arch. Int. Med. **59**: 175 (Feb.) 1937.
47. Joslin, E. P.: The Present Mortality of Diabetic Children: A Remedial and Therefore Hopeful Index of the Future of the Diabetic Child, Ann. Int. Med. **11**: 1348 (Jan.) 1938.

glycemia in children, speaks of one of them as caused by a mistaken diagnosis for diabetic coma in which the patient received 200 units of insulin from a physician who had never seen a case of coma or of any insulin reaction. Root [48] describes the serious effects of insulin hypoglycemia on a heart damaged by coronary disease. He speaks of a patient who received by error an overdose of insulin which proved to be fatal. Ernstene and his co-workers [49] observed that the heart rate is reduced to 50 or 25 per cent of its normal value during these hypoglycemic states—a factor for diminished circulatory rate through the brain. Wohlwill [50] and Beck [51] reported an instance of a patient who suddenly went into fatal insulin shock from diabetic coma. Leyton [42] reported the case of a child aged 5½ years who had been in coma and been restored by insulin. Severe hypoglycemia developed which persisted for ten or eleven weeks, although administration of insulin had been stopped. His symptoms ceased after seven weeks, but the glycosuria was present throughout the entire hypoglycemic state.

(*f*) Cases of marked instability of the blood sugar level were occasionally encountered. In these instances only frequent blood sugar estimations averted severe hypoglycemic reactions. Urine sugar examination alone in such cases would have been a dangerous procedure. Even with the blood examination it was almost impossible at times to preserve the mean between hyperglycemia and hypoglycemia. This occurred not only with protamine and ordinary insulin alone but also in the patients on both forms of insulin.

Patients may have, as observed in the foregoing groups, increased blood sugar above normal with sugar-free urine or urine slightly positive for sugar after meals as well as a "negligible" quantity in twenty-four hour urine. The physician may advise the patient to ignore the trace of sugar in the urine as it is of "no significance." He may be prompted to say this because to allow the presence of sugar in the urine after meals may eliminate the danger of insulin shock or reaction in patients on protamine zinc insulin. This glycosuria is also not infrequently seen in the patient on protamine alone or with ordinary insulin who may have the morning fasting urine sugar free and feel that the diabetes is under good control but, following his meals, he may spill a variable amount of sugar. Wilder,[39] Kepler,[52] Lawrence,[53] Himsworth [54] and others admit the inability of the protamine zinc insulin alone to control the hyperglycemic effects of meals in spite of the fact that the morning urine may be sugar free and the dose of protamine zinc insulin so large that it will provoke a night reaction. They feel that, if the patient is maintained constantly sugar free, reactions of severity are inevitable. Such "control" may probably help to eliminate insulin reactions to an extent, but when one considers that there has been observed in patients after breakfast as well as in the twenty-four hour urine a blood sugar concentration above normal with urine negative for sugar and much higher blood sugar levels with excretion of varying "insignificant" amounts of dextrose, one wonders whether this is controlled at all, especially in view of the increasing diabetic complications.

Of course, the optimum result in the treatment of diabetes is to metabolize the prescribed diet with a postprandial blood sugar that approaches the normal without regard to the analysis of the urine. That this is not always accomplished and that effective diabetic treatment today is far from being well achieved in spite of the new advances—insulin, ordinary or protamine, higher carbohydrate diet and the like—is painfully apparent when one considers the increasing mortality and number of elderly diabetic patients who are becoming invalids either from diabetic gangrene, coronary disease or cataracts. According to Major's [55] statistics the death rate from diabetes mellitus in the registration area of the United States for 1919, three years before the introduction of insulin, was 14.9 per hundred thousand, while the rate in 1925, three years after the introduction of insulin, was 16.9. Comparisons of the ratio of diabetic deaths to total deaths in Massachusetts shows that the ratio in 1920 was 0.86 while in 1925 it was 1.56, or nearly twice as high. Encouragement, however, is given in a study of the age group by the fact that the mortality from juvenile diabetes is distinctly lowered. These observations are somewhat in accord with our observations. Joslin and his co-workers [56] admit that the death rate in diabetes is still much in excess of that for the general population. Also the increase in expectation of life is progressively less with advancing age. The diabetic patient in spite of insulin has not been freed from the entanglements of premature arteriosclerosis and all its allied degenerative lesions. Nevertheless, in spite of these levels of blood sugar above normal in which there is sugar-free urine, many investigators are inclined to believe that protamine zinc insulin alone by its continued action, as based on twenty-four hour urine, will further delay the onset of premature arteriosclerosis. This point of view I decline to accept as a method of adequately controlling a diabetic patient as long as an increased blood sugar level above normal after meals exists with normal urine or a trace of sugar in the fasting, twenty-four hour or postprandial urine. For, surely, if this increased blood sugar above normal, escaping detection by urine tests, is allowed to continue months or years it will probably help to increase the prevalent degenerative complications—premature arteriosclerosis, diabetic ulcer, gangrene or coronary disease.[28]

But has insulin failed to come up to expectations in diabetic treatment or have physicians failed to recognize adequately the role of the disturbed metabolism by gliding over the importance of making chemical examination of the blood? My inference is that the latter is true. The disturbed metabolism cannot be adequately recognized and corrected by determination and correction of urine sugar alone, whether it is of fasting, postprandial or a twenty-four hour specimen. Kepler [52] takes the position that until the cause of arteriosclerosis and allied degenerative lesions is determined one is not justified in assuming that glycosuria is not detrimental to health. Insulin (protamine or ordinary) is not at fault. It is the greatest adjuster adequately

48. Root, H. F.: The Effects of Insulin Hypoglycemia upon the Diabetic Heart in Children and Youth, Ann. Int. Med. **11**: 1332 (Jan.) 1938.
49. Ernstene, A. C.; Riseman, J. E. F.; Stern, Beatrice, and Alexander, Benjamin: The Mechanism of Circulatory Changes Accompanying Insulin Hypoglycemia, Am. J. Physiol. **111**: 440 (March) 1935.
50. Wohlwill, F.: Ueber Hirnbefunde bei Insulin-Ueberdosierung, Klin. Wchnschr. **7**: 344 (Feb. 19) 1928.
51. Beck, W.: Hypoglykämie mit todlichem Ausgang, Klin. Wchnschr. **6**: 212 (Jan. 29) 1927.
52. Kepler, E. J.: Clinical Experience with Protamine Zinc Insulin, J. A. M. A. **110**: 92 (Jan. 8) 1938.
53. Lawrence, R. D., and Archer, Nora: Zinc Protamine Insulin, Brit. M. J. **1**: 487-491 (March 6) 1937.
54. Himsworth, H. P.: Protamine Insulin and Zinc Protamine Insulin in the Treatment of Diabetes Mellitus, Brit. M. J. **1**: 541-546 (March 13) 1937.
55. Major, R. H.: Eight Years of Insulin, J. Kansas M. Soc. **32**: 42 (Feb.) 1931.
56. Joslin, E. P.; Dublin, L. I., and Marks, H. H.: Studies in Diabetes Mellitus: VI. Mortality and Longevity of Diabetics, Am. J. M. Sc. **195**: 577-716 (May) 1938.

applied after blood sugar determination, will help better to decrease the degenerative diabetic complications and mortality rate and finally will aid in making more rapid progress into the possible etiology of diabetes.

We take the position that examination of the urine for sugar as indicative of the degree of blood sugar concentration or carbohydrate disturbances is not to be depended on, for it may be misleading. Diabetic control by urine sugar alone is to be considered not without dangers of unwarranted end results and even with the possibility of fatal hypoglycemia.

DISADVANTAGES OF DETERMINATION OF URINE SUGAR FOR CONTROL OF DIABETES

1. The presence of sugar in the urine does not always exclude a diagnosis of hypoglycemia nor does it always signify diabetes mellitus—perhaps so-called "renal diabetes" or benign glycosuria.

2. A normal urine does not exclude the diagnosis of hypoglycemia in patients on protamine zinc insulin, or after meals in those patients on ordinary and protamine zinc insulin combined, nor does a normal urine eliminate a diagnosis of hyperglycemia.

3. A normal twenty-four hour urine after a regular prescribed diet does not always indicate adequate control of diabetes.

4. "Interpretation" of a trace of sugar in the urine or normal urine without blood examinations may result in improper administration of insulin and mismanagement of the disturbed blood sugar level, hence further adding to inadequate control of the carbohydrate metabolism—either by producing frequent hypoglycemic states and their serious ultimate effects or by frequent hyperglycemia, probably helping to increase the prevalence of premature arteriosclerosis and their associated end results of various degenerative changes, thereby adding to the mortality rate. Thus, just to cite one of the many patients who came under our observation, a woman aged 67 had for years been under the care of a physician who "controlled" her diabetes (diet, activities and the like by examination of the urine). Because of the normal urine, or occasionally of a trace of sugar, which the physician probably considered "of no significance," he did not deem it advisable to undertake an estimation of the blood sugar. When the patient entered our diabetic ward she had diabetic gangrene of the left foot which necessitated a midthigh amputation. Her postprandial blood sugar (two hours after breakfast) was 340 mg. per hundred cubic centimeters.

5. Sugar in the urine is usually interpreted in terms of elevated blood sugar levels. Thus a large amount may be interpreted as a markedly elevated blood sugar, a small amount as moderately elevated. In reality, the former may occasionally, or in fact not infrequently does, show a lower blood sugar than the latter, as revealed by our studies.

6. During coma the patient usually cannot void, and catheterization in such a state for the estimation of sugar is a dangerous procedure because infection of the bladder and genito-urinary tract is not uncommon in diabetic patients. Wauchope [41] speaks of diabetic coma that may occur with profound acidosis in the absence of glycosuria. Kidney function in such states is frequently impaired, owing to toxic injury by products of the abnormal metabolism to the epithelial cells. Gopfert [32] believes that there is a disorder in the renal activity which is responsible for many of the complications that occur. Blatherwick and Medlar's [33] studies of the kidney established the existence of essential changes in the glomerulus and tubules, an impairment that may be brought about as a result of overwork or during metabolism. I believe that the renal impairment, probably the glomerular changes affecting the filtering apparatus, is due perhaps to the marked metabolic disorders that occur in coma or in prolonged hyperglycemia. These metabolic disturbances or irregularities will probably add much in interfering with renal function in such a manner as to cause a loss of quantitative relationship of glycosuria to glycemia.

7. During acute complications—as in infections or surgical conditions—a specimen of urine may be difficult to obtain. Catheterization in such cases would be perhaps a dangerous and unreliable procedure.

8. Drugs may effect a reduction in glycosuria without causing any significant change in the concentration of the blood sugar in diabetes either during fasting or after the ingestion of dextrose; for example, dinitrophenol.[57] The experiments of Kleiner and Meltzer [58] on a group of animals are of interest in that they show by intravenous injection of fourth-molar solution of magnesium sulfate that glycosuria was very little marked and far under proportion to the marked hyperglycemia produced, and often the glycosuria was entirely absent.

9. Cases of diabetes with definite renal disease frequently show no relationship between the hyperglycemia and the glycosuria.[59] The hyperglycemia in such persons is usually greater in proportion to the glycosuria than in those diabetic patients with apparently normal functioning kidneys.

10. Frequent examination of the urine for sugar after one or more meals or on retiring or rising may cause much mental anguish and probably bring about a peculiar mental state. This not infrequently causes the patient to become too diabetes conscious and may hinder his progress.

CONCLUSIONS

No apparent quantitative correspondence existed between the blood sugar and the urine sugar in a large number of patients on protamine zinc insulin and ordinary insulin alone or on the two combined, or without insulin as observed in our studies after regular prescribed meals. Probably renal functional disturbances, which frequently escape detection by laboratory or physical means, brought about by the disturbed carbohydrate metabolism, were sufficient to interfere with the excretion of sugar in such a manner as to cause a partial loss and, at times, a marked loss of quantitative relationship between the urine and the blood sugar.

1. Quantitative increase of dextrose in urine after breakfast in patients on protamine and ordinary insulin or on the two combined may alarm the physician into thinking that the patient has a markedly elevated blood sugar; or, on finding a small quantity, he may interpret it in terms of slightly increased blood sugar. In reality it may be as we observed in a patient who had 289 mg. per hundred cubic centimeters the first hour after breakfast with 23 Gm. of dextrose in the urine, while in another patient on protamine and ordinary insulin

57. Wishnofsky, Max; Kane, A. P.; Shlevin, E. L., and Byron, C. S.: Influence of Di-Nitrophenol on Carbohydrate Metabolism, Arch. Int. Med. **56**: 374 (Aug.) 1935.

58. Kleiner, I. S., and Meltzer, S. J.: On the Production of Hyperglycemia and Glycosuria by Magnesium Salts, Proc. Soc. Exper. Biol. & Med. **13**: 1103 (Dec. 15) 1916.

59. Bailey, C. V.: Studies in Alimentary Hyperglycemia and Glycosuria, Proc. Soc. Exper. Biol. & Med. **13**: 153 (May 24) 1916. Epstein.[32]

it was 410 mg. per hundred cubic centimeters with 1 Gm. of dextrose in the urine. With protamine zinc insulin alone we observed that a patient two hours after breakfast spilled 2.1 Gm. in the urine with a blood sugar of 142 mg. per hundred cubic centimeters; in another patient the blood sugar was 271 mg. with a 0.6 Gm. spill.

Similar observations were obtained in the twenty-four hour urine study. Thus excretion of 3.4 Gm. of sugar was found in a patient on protamine and ordinary insulin with a postprandial blood sugar (two hours after breakfast) of 224 mg. per hundred cubic centimeters, while in another patient it was negative with a postprandial blood sugar of 308 mg. These observations occurred not infrequently in the same patients but also in different patients with either form of insulin alone.

2. A normal urine does not eliminate the diagnosis of hypoglycemia. Patients taking protamine with ordinary insulin can maintain a lower blood sugar level than they can on either ordinary or protamine zinc insulin alone, and at times hypoglycemic levels before breakfast and between meals, without any apparent symptoms which cannot be detected by urine examination. With protamine zinc insulin alone, fasting blood sugar has been maintained at a lower level than with ordinary insulin. Such a hypoglycemic state escaping detection by urine examination alone, and allowed to continue at frequent intervals for an indefinite period, may, as shown, prove of serious consequences.

3. The amount of sugar in fasting, postprandial or twenty-four hour specimen of urine should not be depended on:

(*a*) To interpret or correlate blood sugar levels or concentration. (No corresponding quantitative relationship was found between blood sugar and urine sugar in patients on protamine or ordinary insulin or on the two combined or without insulin in our observations of the sugar in blood and urine after meals in patients on higher carbohydrate diets.)

(*b*) To judge insulin (protamine and ordinary) dosage or control the disturbed blood sugar fluctuation, because (1) of the danger of the presence of hypoglycemia with urine positive for sugar resulting in serious consequences; (2) normal urine, whether in fasting or in twenty-four hour specimens, does not show the occasional or not infrequent elevated blood sugar above normal or frequent higher "peaks" or levels after meals.

4. In view of the high incidence of disturbed carbohydrate metabolism frequently escaping detection by examination of the urine for sugar and the serious consequences resulting therefrom, blood sugar estimations, fasting and after meals, should be indispensable in early and latent recognition and treatment of the blood sugar disturbances:

(*a*) They should be the governing factor in guiding the insulin dose and diabetic treatment.

(*b*) Control of the hyperglycemia, not the glycosuria, should be the paramount aim of diabetic treatment. This is not difficult when one considers the hundreds of diabetic patients on protamine and ordinary insulin combined or alone, coming to clinics every four to eight weeks a distance of many miles from the hospital. This is more true of the private patients coming a distance of hundreds of miles once every six to twelve weeks with little or no risk of hypoglycemia or insulin reactions.

5. An increased blood sugar level above normal or frequently higher levels after meals, a definite sign of disturbed carbohydrate metabolism, not revealed adequately by urine sugar, is to be considered in the absence of definite etiology of arteriosclerosis a pathologic disorder probably helping to precipitate premature arteriosclerosis in diabetes.[28] The increased incidence of diabetic complications such as premature arteriosclerosis, gangrene and coronary sclerosis, in spite of insulin and improved therapy, leads to the realization that one should concentrate more on blood chemistry and less on urine sugar.

6. There exists a welter of confusing theorization about the method of interpreting the dextrose in the urine as related to the blood sugar concentration. The renal "threshold" for dextrose is still a subject of much controversy and is an unsettled problem among various investigators throughout the world. From our observations, after meals, of the regulated prescribed diets in diabetes we feel that if a renal threshold exists it is variable not only in the same patient but also in different patients. The mechanism responsible for this variation of renal "threshold" in diabetes is unknown, but probable factors which may influence it are (*a*) constantly changing circulatory environment on which the renal functional response depends,[36] (*b*) the presence of infections, (*c*) infections complicated or associated with hypertensive heart disease, (*d*) arteriosclerosis, (*e*) probably disturbances of the utilization of sugar by kidneys in similar way as of other tissue,[37] (*f*) age—in the older age group as compared with the young the kidneys are frequently already impaired,[34] (*g*) acidosis or coma, (*h*) prolonged hyperglycemia, as in long continued, mild, uncontrolled diabetes or in irregularly controlled severe disease,[5] (*i*) insulin, (*j*) diet, (*k*) kidney and bladder disease, (*l*) anemia,[21] (*m*) exercise,[60] (*n*) neurologic disturbances,[61] (*o*) endocrine factor,[62] (*p*) hypoglycemia states, (*q*) drugs,[63] (*r*) individual variations and (*s*) pregnancy. Page and Corcoran[5] state that it is impossible to assume that the kidney is normal in diabetic patients with arteriosclerosis whether uncomplicated or associated with hypertension or chronic nephritis and also in those with an infection, although the available tests of renal function may not show evidence of marked abnormality.

Thus in spite of such disadvantages in taking blood sugar tests as (1) complicated apparatus or equipment as compared with the simple equipment necessary for urine sugar examination, (2) the fact that the apparatus cannot be transported as easily as apparatus for the estimation of sugar in the urine, (3) the fact that blood specimens must be obtained by a technician or a physician and be examined by a laboratory technician or physician and not by the patient, (4) the complicated technical procedure for blood sugar estimations and (5) the fact that there is danger of infection when blood is taken, it is nevertheless most important to examine the blood for sugar because of the significance and accuracy of the information it gives as to the true state of the diabetes.

1315 Pine Street.

60. Norris, E. R., and Weiser, R. S.: The Influence of Strenuous Muscular Exercise upon Renal Excretion, Am. J. Physiol. **119**: 642-650 (July) 1937.

61. Munch-Peterson, C. J.: Pathogenesis of Renal Glycosuria, Hospitalstid. **80**: 885-896 (Aug. 10) 1937. Cannon, W. B.: Bodily Changes in Pain, Hunger, Fear and Rage, ed. 2, New York, D. Appleton & Co., 1929.

62. Cushing, Harvey: The Pituitary Body and Its Disorders, Philadelphia, J. B. Lippincott Company, 1912.

63. Wishnofsky, Kane, Shlevin and Byron.[57] Kleiner and Meltzer.[58]

Clinical Notes, Suggestions and New Instruments

HEMOCHROMATOSIS: DIAGNOSIS AT AUTOPSY, DEATH BEING DUE TO PERFORATED DUODENAL ULCER

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DETROIT

A recent review [1] of the literature of hemochromatosis since the monograph of Sheldon [2] reports altogether 387 acceptable cases of the disease on record.

We add an additional case, in which hemochromatosis was an unexpected observation at autopsy following death from a perforated duodenal ulcer.

REPORT OF CASE

History and Examination.—J. W. S., a white man aged 52, a brewery worker, admitted to the hospital Sept. 15, 1937, complained of an umbilical hernia which had gradually increased in size. He stated that he drank beer moderately. He had been told several years previously that he had diabetes.

Except to reveal a blood pressure of 165/100 and a fairly large umbilical hernia, the routine physical examination at admission gave essentially negative results. The first urinalysis showed a slight trace of sugar, but repeated subsequent examinations showed none. The Kahn reaction of the blood was negative.

Course.—Two days after admission, repair of the umbilical hernia was begun. When the peritoneum was incised 500 cc. of straw-colored fluid escaped from the abdominal cavity. The liver was small, firm and nodular. An omentopexy was done and the hernia repaired.

Subsequent to the operation ascites recurred frequently, necessitating repeated paracenteses. He lost weight, gradually weakened and died March 14, 1938, about six months after admission. Prior to death there were no unusual abdominal complaints and no fever.

The clinical diagnoses were (1) atrophic cirrhosis of the liver and (2) chronic alcoholism.

Autopsy.—The skin of the anterior surface of the legs presented a small amount of brown mottling. The abdominal cavity was partly filled with turbid greenish fluid, which was more abundant in the artificial upper abdominal division made by the omentopexy. The parietal peritoneum was dark red and thickened. Friable fibrinous exudate covered the organs above the site of the omentopexy. Lying in the anterior wall of the duodenum at the pylorus was a crateriform ulcer which had perforated.

The liver, which weighed 1,575 Gm., showed beneath the fibrinous exudate a finely to coarsely nodular surface and was strikingly yellowish brown. The consistency was greatly increased, and the surface of the cut section was studded with yellowish brown nodules which measured from 2 to 4 mm. in diameter and were surrounded by much less pigmented copious stroma. The pancreas weighed 160 Gm. It had the same yellowish brown color as the liver, and its consistency was firm. Sections of the liver and pancreas when wet with potassium ferrocyanide and dilute hydrochloric acid gave the brilliant blue-green color of hemosiderin.

The thyroid was similarly but less deeply pigmented. No other organs were pigmented. The lungs showed some edema and congestion. The other organs showed no changes of note.

Microscopic Examination.—The liver exhibited marked thickening of the periportal stroma made up of proliferating fibroblasts, collagen, capillaries and proliferating bile ducts. Enveloped by this hyperplastic stroma were nodules of liver cords without central veins. Practically all the liver cord cells were laden with more or less centrally arranged granular brown pigment which reacted positively for hemosiderin. Much similar pigment was seen in Kupffer cells. In the stroma it was observed in macrophages, fibroblasts and duct epithelium or as extracellular granules.

The pancreas showed fine perilobular and peri-insular thickening of moderately well collagenized connective tissue. The islands of Langerhans, which were generally large and numerous, presented an increase in interstitial connective tissue. A few were compressed by scar tissue. Much finely granular pigment was deposited in the stroma, in the islands and in the acinar epithelium.

Large quantities of hemosiderin were observed also in a chronically inflamed pancreatic lymph node. The acinar epithelium of the thyroid gland was also heavily laden with the pigment.

The stratum glomerulosum of the adrenal cortex exhibited a small quantity of pigment in its stroma. Small granules of hemosiderin were seen in cardiac muscle fibers in the epithelium lining the convoluted tubules of the kidney. The spleen exhibited the thick-walled gaping sinuses and increased pulp stroma of chronic passive congestion. Much hemosiderin was found beneath the capsule and in the pulp.

The testicle showed no hemosiderin. A section of skin taken from the anterior surface of a leg exhibited considerable hemosiderin, deposited chiefly about sweat glands and small blood vessels of the corium.

Histologic examination indicated a chronic duodenal ulcer and an acute peritonitis which was probably of several days' duration.

COMMENT

This case of hemochromatosis with portal cirrhosis and ascites was terminated prematurely by the perforating duodenal ulcer. The classic triad of cirrhosis, diabetes and bronzing of the skin was not fully developed. Impaired dextrose metabolism was suggested by the slight trace of sugar found at the admission urinalysis and the history of alleged diabetes. Pigmentation of the skin, which was limited to the mottling of the anterior surface of the legs, was scarcely enough to arouse suspicion.

It is of interest that there were no signs or symptoms indicative of a chronic duodenal ulcer or of its perforation and resultant peritonitis.

1. Binford, C. H.; Lawrence, R. L., and Wollenweber, H. L.: Hemochromatosis with Primary Carcinoma of the Liver, Arch. Path. **25**: 527 (April) 1938.
2. Sheldon, J. H.: Haemochromatosis, New York, Oxford University Press, 1935.

MARKED EOSINOPHILIA IN HODGKIN'S DISEASE

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Eosinophilia is not a rare phenomenon, but patients with an eosinophil count exceeding 90 per cent are very uncommon. In the following case the differential count showed an eosinophil count which was constantly above 90 per cent and on several occasions as high as 98 and 99 per cent.

REPORT OF CASE

History.—R. C., a Negro aged 21, referred by Dr. Robert Moore of Lansing, Kan., admitted to the University of Kansas Hospitals April 14, 1938, complained of fever, sweats, weakness and loss of weight. The family history was essentially negative. There was no history of tuberculosis, carcinoma, diabetes, epilepsy or heart disease. The personal history was essentially negative.

In 1936 the patient was in an automobile accident and injured his right biceps. Nov. 20, 1937, he was operated on for repair of the injury and during the month of December suffered from what he described as "pleurisy pains" in the left side of the chest. Shortly afterward he began to have fever, which continued intermittently until his death. The latter part of January he began to have a dry cough and soon afterward swollen glands developed in the left side of the neck. One of these glands was removed for diagnosis April 2, 1938, and was sent to the University of Kansas Pathological Laboratory for diagnosis. The diagnosis was "Hodgkin's sarcoma of lymph gland, acute

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lymphadenitis." The patient, since the beginning of his illness, had lost 75 pounds (34 Kg.).

Examination.—The patient was very poorly nourished. The nails and mucous membranes were very pale. The cervical, supraclavicular and occipital lymph glands were palpable and somewhat enlarged. There was a draining sinus in the left side of the neck. The chest showed an impairment of the percussion note on the left side and numerous musical rales. The heart was normal; the pulse rate was 96 and the blood pressure 135 systolic and 85 diastolic. Examination of the abdomen revealed the liver just below the costal margin; the spleen was not palpable.

Urinalysis showed a trace of albumin and was otherwise negative. The blood on admission showed red blood cells 4,300,000, white blood cells 61,000, hemoglobin content 71 per cent (11 Gm. per hundred cubic centimeters), blood platelets 210,000, color index 0.82, volume index 0.96. The differential count showed polymorphonuclear leukocytes 2 per cent, lymphocytes 3 per cent, eosinophils 93 per cent, monocytes 1 per cent, myelocytes 0, metamyelocytes 1 per cent, lymphoblasts 0. A filament count on the eosinophils showed filament forms 76, nonfilament forms 17. The results of a series of blood counts are shown in the accompanying table.

Blood Counts

Date	White Blood Cells	Polymorphonuclears	Filament Forms	Nonfilament Forms	Lymphocytes	Eosinophils
4/14/38	61,000	4	1	3	3	93
4/15/38	56,500	2	2	0	4	93
4/16/38	60,000	2	2	0	3	95
4/18/38	64,000	7	4	3	..	90
4/19/38	74,000	3	3	0	..	94
4/20/38	85,000	0	..	..	3	97
4/21/38	120,000	4	1	3	2	94
4/22/38	169,000	4	2	2	1	95
4/23/38	126,000	7	6	1	2	91
4/25/38	147,000	6	2	4	1	93
4/26/38	119,000	4	2	2	1	95
4/27/38	118,000	7	6	1	3	90
4/29/38	112,000	2	1	1	..	91
4/30/38	115,000	4	2	2	5	91
5/ 2/38	93,000	..	..	..	..	99
5/ 3/38	91,000	..	..	..	1	99
5/ 4/38	86,000	1	0	1	2	97
5/ 5/38	74,000	..	..	..	1	99
5/ 6/38	59,000	..	..	..	1	99
5/ 7/38	55,000	1	..	..	1	98
5/ 9/38	50,000	1	..	..	1	98
5/10/38	57,500	7	6	1	1	92
5/11/38	37,500	10	6	4	3	87

The patient continued to have profuse sweats and daily elevations of temperature; he gradually grew weaker and died May 12. An autopsy was performed the same day by Dr. R. A. Richeson. The anatomic diagnosis was abdominal Hodgkin's sarcoma with metastases to the parietal pleura, dura mater and retroperitoneal lymph nodes; acute and chronic lymphadenitis; hyperplastic bone marrow; acute dilatation of the heart, bilateral hydrothorax, hydropericardium and hydroperitoneum.

COMMENT

The question arose at first as to whether this patient was suffering from eosinophilic leukemia. Against this diagnosis were the absence of myelocytes, the absence of an enlarged spleen and the pathologic report that the excised lymph gland under the microcope showed Hodgkin's disease. The high white blood cell count at first glance would seem to be against the diagnosis of Hodgkin's disease, but examination of the literature shows that counts have been recorded in which the white blood count was as high as 75,000, and in one case reported by Stewart [1] the white blood count was 130,000 and the percentage of eosinophils varied from 72 to 90.

1. Stewart, S. G.: Eosinophilic Hyperleukocytosis in Hodgkin's Disease with Familial Eosinophilic Diathesis, Arch. Int. Med. **44**: 772-783 (Nov.) 1929.

The high percentage of eosinophils in Hodgkin's disease seems to be, however, the exception. Roth and Watkins [2] in their study of forty cases of Hodgkin's disease found the eosinophil count within normal limits. Sears [3] reports a case in which there was an eosinophil count as high as 57 per cent and has collected from the literature a series of fourteen cases in which the eosinophil counts were 44, 68, 68, 36, 26, from 65 to 80, 68, 33, 16, 85, 60, 40, from 72 to 90 per cent, the last count being that of Stewart, to which reference has been made.

In our case it is noteworthy that there was only one count recorded below 90 per cent, and in four counts the percentage of eosinophils was 99.

Council on Physical Therapy

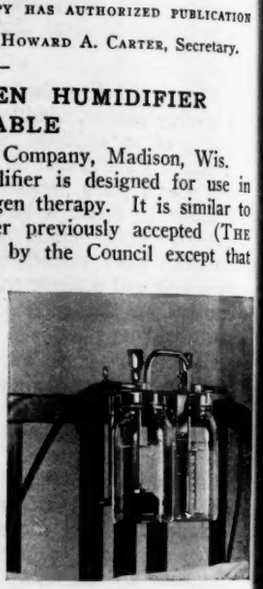
THE COUNCIL ON PHYSICAL THERAPY HAS AUTHORIZED PUBLICATION OF THE FOLLOWING REPORT.

HOWARD A. CARTER, Secretary.

UNIVERSITY OXYGEN HUMIDIFIER ACCEPTABLE

Manufacturer: Scanlon-Morris Company, Madison, Wis.

The University Oxygen Humidifier is designed for use in the nasal catheter method of oxygen therapy. It is similar to the Wisconsin Oxygen Humidifier previously accepted (THE JOURNAL, June 3, 1939, p. 2276) by the Council except that this unit has only two glass jars, the third, a trap jar, being omitted, and that it can be mounted on the back of the bed. One bottle serves to humidify the oxygen and the other to measure the rate of oxygen flow. Both are mounted on a chromium-plated brass frame with carrying handle and rubber-covered adjustable arms for attachment to the head of the bed. Equipment includes rubber tubing to connect the oxygen cylinder and the nasal catheter with the bottles, a glass adapter to connect the catheter with the tubing, and four nasal catheters with perforated tips. Quart size mason jars are used to permit quick replacement in case of breakage.



University Oxygen Humidifier.

A special carbon filter is installed in the humidifier through which oxygen passing from the oxygen cylinder is broken into the fine bubbles for the purpose of saturation with water. The flow-gage chamber indicates approximately the flow of oxygen in liters per minute. Both chambers should be kept partially filled with water by means of filling cups. It is possible to adjust the rate of flow through the humidifier from 1 to 10 liters per minute.

The manufacturer submitted the following data in support of the efficiency and accuracy of the unit: In humidity tests run at a rate of 6 liters flow per minute, the usual rate employed, approximately 93 per cent relative humidity was found in the gas leaving the unit. This was cut down somewhat by air dilution in the pharynx. The advantage of this unit over the three-jar type is solely that of convenience, in that it lends itself to hanging on the head of the bed, is out of the way, and is easily seen by nurses for checking.

The unit was examined by a qualified investigator, who confirmed the claims of the manufacturer and found the apparatus adequate in humidification of oxygen.

From a review of the data, however, the Council concluded that there are faults in the fundamental principles of this type of nasal catheter treatment. Even though the flowmeter may indicate a therapeutic rate of flow, all too frequently more than half of this amount is lost to the patient. The hazard of break-

2. Roth, Grace M., and Watkins, C. H.: The Leukocyte Picture in Hodgkin's Disease, Ann. Int. Med. **9**: 1365-1372 (April) 1936.

3. Sears, W. G.: The Blood in Hodgkin's Disease, with Special Reference to Eosinophilia, Guy's Hosp. Rep. **82**: 40-54 (Jan.) 1932.

age of glass above the patient as well as the decay of rubber gaskets in the presence of oxygen is also to be considered.

In view of the foregoing report, in which the claims of the manufacturer are substantiated, the Council on Physical Therapy voted to include the University Oxygen Humidifier in its list of accepted devices.

Council on Pharmacy and Chemistry

REPORTS OF THE COUNCIL

THE COUNCIL HAS AUTHORIZED PUBLICATION OF THE FOLLOWING REPORT.

PAUL NICHOLAS LEECH, Secretary.

ACCEPTANCE OF BRANDS OF SULFAPYRIDINE

Three brands of sulfapyridine were submitted to the Council, respectively, by the Calco Chemical Co., Inc., Lederle Laboratories, Inc., and Merck & Co., Inc. In the consideration of these brands there arose the question of proprietary names. The firms were advised as follows:

> The Council voted to accept products labeled "Sulfapyridine" with the understanding that a firm may apply for recognition of the right to a proprietary name at a later date. However, until such time as satisfactory evidence has been submitted to warrant the Council's recognition of a proprietary name for sulfapyridine of one of the firms, the name "Sulfapyridine" shall be used; of course it is understood that the proprietary name shall be of an acceptable type.

Merck and Lederle were also advised that they could use the subtitle "Introduced as Dagenan—M & B 693" on labels and in advertising for a period of one year, after which it must be removed unless in the meantime the right to a proprietary name has been established; that the name must not only be acceptable by rights of proprietorship but that the name itself must be of an acceptable type.

NEW AND NONOFFICIAL REMEDIES

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION.

PAUL NICHOLAS LEECH, Secretary.

SULFAPYRIDINE (See THE JOURNAL, May 6, 1939, p. 1831).

Sulfapyridine-Calco.—A brand of sulfapyridine-N. N. R.

Manufactured by The Calco Chemical Co., Inc., Bound Brook, N. J. U. S. patent applied for. No U. S. trademark.

Tablets Sulfapyridine-Calco, 0.5 Gm. (7.7 grains).

Sulfapyridine-Lederle.—A brand of sulfapyridine-N. N. R.

Manufactured by Lederle Laboratories, Inc., Pearl River, N. Y., by license of May & Baker, Ltd., Dagenham, England. U. S. patent applied for. No U. S. trademark.

Tablets Sulfapyridine-Lederle, 0.5 Gm. (7.7 grains).

Sulfapyridine-Merck.—A brand of sulfapyridine-N. N. R.

Manufactured by Merck & Co., Inc., Rahway, N. J., by license of May & Baker, Ltd., Dagenham, England. U. S. patent applied for. No U. S. trademark for sulfapyridine.

Tablets Sulfapyridine-Merck, 0.5 Gm. (7.7 grains).

SULFANILAMIDE (See New and Nonofficial Remedies, 1938, p. 450; THE JOURNAL, Feb. 25, 1939, p. 733).

Tablets Sulfanilamide, 5 grains-The Upjohn Company.

Prepared by The Upjohn Company, Kalamazoo, Mich. No U. S. patent or trademark.

Tablets Sulfanilamide, 7½ grains-The Upjohn Company.

Prepared by The Upjohn Company, Kalamazoo, Mich. No U. S. patent or trademark.

CORRECTION

Iodobismitol with Saligenin-Cutter.—In the published description of the product in THE JOURNAL, June 3, page 2279, the phrase "and from 0.318 to 0.258 Gm. of sodium iodide" should read "and from 0.218 to 0.258 Gm. of sodium iodide."

Council on Foods

ACCEPTED FOODS

THE FOLLOWING PRODUCTS HAVE BEEN ACCEPTED BY THE COUNCIL ON FOODS OF THE AMERICAN MEDICAL ASSOCIATION AND WILL BE LISTED IN THE BOOK OF ACCEPTED FOODS TO BE PUBLISHED.

FRANKLIN C. BING, Secretary.

CELLU BRAND PEACH JUICE

Distributor.—Chicago Dietetic Supply House, Inc., Chicago.

Description.—Canned peach juice packed without added sugar.

Manufacture.—Choice yellow cling peaches on which no toxic spray material has been used and which are too soft for the regular pack as halves are selected, pitted, peeled, trimmed to remove blemishes, preheated, crushed and pressed through special mesh cloths in a hydraulic press. The juice, containing some of the insoluble solids which are left in to lend color, is filled into cans and heat processed.

Analysis (submitted by distributor).—Moisture 88.7%, total solids 11.3%, ash 0.4%, fat (ether extract) 0.4%, protein (N × 6.25) 0.4%, crude fiber 0.04%, carbohydrates other than crude fiber (by difference) 10.1%, invert sugar 4.58%, sucrose 4.62%.

Calories.—0.5 per gram; 14 per ounce.

V-B-W (VITAMIN B_1 WAFER)

Manufacturer.—Hilker & Bletsch Company, Cincinnati.

Description and Use.—Packaged cookies prepared from wheat flour, sucrose, hydrogenated shortening, eggs, dextrose, powdered skimmed milk, salt, baking powder, flavoring, with added thiamin chloride to furnish about 100 international units of vitamin B_1 per wafer. Intended as a special purpose food providing vitamin B_1 in convenient form.

Manufacture.—Crystalline vitamin B_1 (thiamin chloride) is mixed with a small amount of sugar and in turn is thoroughly mixed (creamed) with definite proportions of sugar, hydrogenated shortening, dextrose, powdered skimmed milk, salt and flavor. The eggs are thoroughly worked in, water is added, and the flour and baking powder are worked in. The wafers are mechanically cut, placed on trays, and baked under conditions designed to maintain a standard vitamin B_1 content.

Analysis (submitted by manufacturer).—Moisture 2.3%, total solids 97.7%, ash 1.0%, sodium chloride 0.58%, fat (ether extract) 11.4%, protein (N × 6.25) 6.6%, crude fiber 0.12%, carbohydrates other than crude fiber (by difference) 78.6%, calcium (Ca) 0.079%, phosphorus (P) 0.039%.

Calories.—4.4 per gram; 125 per ounce; 15 per 3.41 gram wafer. Wafer count to the pound, about 133.

Vitamins.—Reports of biologic and chemical assay submitted by the manufacturer indicate that V-B-W (Vitamin B_1 Wafer) contains not less than 100 international units of vitamin B_1 in each wafer.

CELLU BRAND JUICE-PAK FRUIT COCKTAIL

Distributor.—The Chicago Dietetic Supply House, Inc., Chicago.

Description.—Canned mixture of diced peaches, pears, whole Thompson seedless grapes, diced pineapple and whole Royal Ann cherries packed in mixed juice.

Manufacture.—Canned Royal Ann cherries (packed in juice) are counted into the cans by hand. Fresh peaches, fresh pears and canned pineapple (packed in juice) are mechanically diced and automatically filled into cans along with whole, fresh Thompson seedless grapes. Juice from the cherry and pineapple stock and that pressed from fresh peaches and pears are blended and added. The cans are heated, sealed and heat processed.

Analysis (submitted by manufacturer).—Moisture 89.1%, total solids 10.9%, ash 0.3%, fat (ether extract) 0.3%, protein (N × 6.25) 0.4%, invert sugar 7.4%, sucrose 1.4%, crude fiber 0.4%, carbohydrates other than crude fiber (by difference) 9.5%.

Calories.—0.42 per gram; 12 per ounce.

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SATURDAY, JUNE 24, 1939

THE INDEX NUMBER

In this issue of THE JOURNAL, which is the Index Number, it has been necessary to abbreviate some departments and to omit others entirely because of the scope of the index. It is recommended particularly that readers consult page 2648 of the index under the heading "American Medical Association." A survey of the material listed will indicate the vast scope of the activities of the Association at this time. It is in a sense a review of the work for the first six months of the year. Few people realize the information to be derived merely from turning the pages of an index one by one. For example, the relative amounts of material on page 2650 concerned with anaphylaxis and allergy and with androgens indicate the extraordinary development of interest in the latter subject during the period covered by this volume. No other medical periodical provides in a six months period the amount of information available through THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. It is with pardonable pride that we assert that the physician who wants to keep abreast of scientific, political, economic, social, literary or any other phases of medicine can do so by consistent, thorough reading of this publication.

THE RELIEF OF PAIN IN CHILDBIRTH

Ideal methods for relieving the pain of childbirth have been the goal of obstetricians since ancient times. Inscriptions and drawings left by early Egyptians [1] indicate that they tried unsuccessfully. Less than a century has elapsed since Sir James Y. Simpson of Edinburgh first used an anesthetic, a few drops of chloroform, for this purpose. In 1880 Klikowitsch introduced the use of nitrous oxide, a method popularized by J. Clarence Webster, Frank Lynch and Carl H. Davis of Chicago, and by Guedel of Indianapolis. Some years before, Steinbuchel, and Gauss of Germany, had suggested the use of scopolamine and morphine for alleviating labor pain, a method which under the name "dammerschlaf," or "twilight sleep," for a time was immensely popular. As originally employed, this method was soon discarded because of uncertain results, with an increase in maternal and fetal mortality. A modification of this method, however, is still widely used. In 1913 Wallace of New York experimented with ether-oil rectal anesthesia, and his results later were applied clinically in the Lying-In Hospital by Davis and by Gwathmey. The barbiturates then came into use for the relief of labor pains. Hirst and his associates reported their results with sodium amytal in thirty cases in 1929, in which year Vogt and Kautz reported on the obstetric use of pernocton. In 1933 Whitfield published his results in 744 cases in which he used several of the foregoing methods. Obviously many different methods are now employed in various parts of this country for the relief of labor pains. In 1936 Insulander [2] came to the United States from Sweden to study the developments. Twenty well known hospitals in widely separated cities were visited and it was found that in every one of these hospitals a different technic was used. If the same drugs were used, the dose or method of application differed. It was difficult to evaluate the numerous methods because the obstetrics observed in America was fundamentally different from that in general use in Sweden. The impression obtained was that in many places here the plan was to favor intervention in labor as much as possible, whereas in Sweden they favor as little intervention in labor as possible. In some hospitals the deliveries were all operative and the physician who could show only 25 per cent operative deliveries was considered too conservative. Insulander found that the obstetricians themselves thought that the drugs used decidedly caused an increase in the number of artificial or operative deliveries. In Germany it was found that analgesics at childbirth were sparsely used, as they are also in Sweden. Indeed, in parts of the United States there is a definite reaction against their widespread use.

Nevertheless, an increasing number of physicians in the United States are using obstetric amnesia or analgesia. To determine the trend as to methods, Bushnell obtained the opinions of seventy-three obstetricians. The concept of polypharmacy permeated the replies. Many obstetricians use not only a hypnotic but also an amnesic and some include an anesthetic. Pentobarbital sodium either alone or in association with other drugs seemed to have the greatest number of advocates in this representative group. Rectal ether-oil is employed either in the usual modified Gwathmey technic or as an inhibitor of the barbiturate excitements. Ethylene and oxygen are used by many for analgesia and anesthesia, as is nitrous oxide and oxygen. Paraldehyde, alone or in combination, has a large number of adherents. Local anesthesia was used by seven of the obstetricians. Cyclopropane was recommended by

1. Bushnell, Lowell F.: The Trend of Obstetrical Amnesia and Analgesia, Surg., Gynec., & Obst. **67**: 155 (Aug.) 1938.

2. Insulander, Margit: Relief of Pains in Childbirth, Acta obst. et gynec. Scandinav. **18**: 179. 1938.

one, three used spinal anesthesia, one clinic uses heroin and even chloroform is still used.

Though the barbiturates are popular, experience has shown that they are far more than simple hypnotics. Indeed, physicians should not attempt to use any drug for analgesia and amnesia without full understanding of its properties. Irving, Berman and Nelson [3] a few years ago made a clinical evaluation of eight methods in use at that time. Pentobarbital sodium and scopolamine gave them the best results. Among 860 patients, 86 per cent had absolute loss of memory of labor. There were no failures, and no stillbirths due to the effects of the drugs.

Bushnell outlines the routine in use by many advocates of this drug. The patient should eat frequent small meals when labor is imminent and abstain from eating solid food after regular pains have begun. Indications for the initial dose varies with obstetricians. The dose commonly used is between 4½ and 9 grains (0.3 and 0.6 Gm.), depending on the patient's weight. It is accompanied by a single dose of scopolamine ranging from $\frac{1}{200}$ to $\frac{1}{100}$ grain (0.00032 to 0.00065 Gm.). The barbiturate is usually given by mouth and the scopolamine subcutaneously; in nauseated patients it may be given rectally. The patient should be under the constant care of an experienced attendant who does not disturb or restrain her. Restlessness between pains is the usual indication for additional dosage, usually by rectal insertion of a perforated capsule. Most obstetricians agree that this method is contraindicated in patients who are poor anesthetic risks, who have acute liver damage or heart disease and who show any pulmonary or upper respiratory pathologic conditions. The majority believe that the method is contraindicated in home obstetrics. Whitfield [4] has recently described a method of giving paraldehyde in capsules in combination with pentobarbital sodium and morphine which, he says, is applicable to home as well as to hospital obstetrics.

Certain objections have been offered to the use of obstetric amnesia and analgesia. The objectors condemn the prophylactic use of outlet forceps. All drugs, they say, reduce uterine contractions and interfere with the normal uterine function. The change in the uterine activity predisposes to hemorrhage. All analgesics have a depressing effect on the respiratory center of the fetus. Spontaneous delivery when easy is a preventive of birth trauma. Childbearing is an essential experience to a woman, which should not be changed from its normal course because of the possible danger of her own personality.

The ideal drug or combination of drugs has not yet been discovered. Perhaps in the hands of masters all of the methods mentioned are essentially safe for both mother and baby. The skilled obstetrician, at least, has the opportunity to choose the particular technic best suited to each case. The enthusiasm and great interest in this problem offer hope for the development of still better methods of relieving the pain of childbirth.

3. Irving, Frederick C.; Berman, Saul, and Nelson, H. B.: The Barbiturates and Other Hypnotics in Labor, Surg., Gynec. & Obst. **58**: 1 (Jan.) 1934.

4. Whitfield, James M.: Present Day Practice of Painless Obstetrics, Virginia M. Monthly **65**: 492 (Aug.) 1938.

THE AGING PROCESS

The life expectancy at birth in such countries as the Netherlands, Switzerland and New Zealand is slightly greater than that in the United States. In several of our Northern states, however, the figures reflect a better experience than that recorded in most foreign countries. The explanation appears to lie in the much lower life expectancy among Negroes, a fact which tends to distort the conclusions which might be drawn from examination of only the comparative gross statistics. There is no doubt, therefore, that the life expectancy of the white population of the continental United States is as long as or longer than that of any other country in the world, although that of Negroes is disturbingly out of proportion.

The control of the communicable diseases has been the most important factor in increasing average longevity; in fact, except for tuberculosis and for pneumonia, all the other infections have been almost eliminated as factors of importance so far as the death rate is concerned. For tuberculosis there has been a decrease in the average death rate since the decade from 1856 to 1865 of more than 90 per cent. With better understanding of the epidemiology and the social and individual factors involved in the spread of this disease, tuberculosis as a cause of death will probably recede still further in importance. If this occurs, as may be reasonably anticipated, ordinary foresight should lead some of the sanatoriums now devoted to the care of the tuberculous to consider their probable functions at some later time when their facilities may not be completely occupied by patients with this disease.

For pneumonia, the record has not been as good as for tuberculosis. From an average death rate of 107 per hundred thousand of population in 1856-1865 the decrease is only to 96 per hundred thousand of population in 1936. Today, however, with increased knowledge of etiology, of epidemiology, of diagnosis and especially of newer forms of treatment, a relatively short span of years should remove pneumonia from its exalted position as third among the causes of death.

Highly unsatisfactory has been the experience with the large number of accidents which maim or destroy human life in the home, on the highway or in the factory. According to insurance statistics, the amazing number of 104,000 persons died accidentally in the United States in 1937. Since accidents rate high among the causes of death, their material reduction would further favorably affect average longevity.

The two metabolic diseases most likely to interfere with aging are obesity and diabetes. These disorders may be partially classed as metabolic and associated

with the aging process but are also influenced by hereditary and nutritional factors. Since this is the case, the fact that the nutritional requirements of older persons are less per kilogram of body weight deserves constant reiteration. Important also are the foods, particularly such proteins as are contained in liver, and the vitamin B complex and iron.

With the decline of the birth rate and the coincidental increase in the number of individuals living to mature and later years, the character of the national population is being slightly modified. As a result, Piersol and Bortz [1] feel that the temper of the people is bound to assert itself in certain important changes which will extend into all the various phases of social, economic, political and professional life. A more mature national mind, they believe, should have a steadying influence on the life of a nation. Already many industries have modified their views on workers in the older years. It is beginning to be appreciated that those over 40 often bring to an industry certain advantages more than compensating for any alleged fault associated with the older years. Since at present 260 of every thousand persons living in the United States are 40 years old or over and since it is estimated that 36 per cent of the population will be between 40 and 65 years old by 1960, the problem of industrial adjustment to this development is already here.

Current Comment

GENESIS OF APPENDICITIS

From sixteen to eighteen thousand persons continue to die each year in the United States from appendicitis. Through the years from ages 5 to 19 the disease ranks as the second to the fifth most frequent cause of death. In the ensuing years, whereas its toll of life remains largely the same for several decades, appendicitis wanes in significance because other more frequent causes of death appear. Incidentally the mortality from appendicitis is higher by occupation among physicians and surgeons than among the population at large. Wangensteen [1] has done much to elucidate the problem of causation. Gerlach's valve, which is a fold overlying the appendical orifice, is believed to interfere with or preclude the filling of the lumen of the appendix. Its absence, as frequently occurs, would facilitate obstruction of the appendix and consequent inflammatory reaction. In a series of ingenious observations on the lumen of the appendix, Wangensteen found that human appendixes which were not obstructed had a luminal capacity at 20 cm. of water pressure of only 0.23 cc.; at 60 cm. pressure the highest luminal capacity was 0.7 cc. When the attempt was made to break the normal appendix by increasing the pressure, it was found that none of three appendixes directly following excision could be ruptured by pressures as high as 2,400 cm. of water. Gangrenous, unruptured appendixes, however, were found to break at extremely low pressures, one at 20 cm. of water and another at 70 cm. Apparently, therefore, the presence of an inflammatory reaction in the appendical wall greatly decreases strength. Further experimental evidence indicated that the vermiform appendage of the rabbit will perforate quite regularly after about ten to fourteen hours of obstruction. All of the varieties of appendicitis recognized by pathologists may be produced by luminal obstruction in animals whose vermiform appendage possesses the capacity to secrete fluid as does that of man. Fecaliths and swelling of lymphoid tissue are probably the most frequent causes of appendical obstruction in man. Kinks, bands, position (retrocecal) and stenoses may also cause obstruction. The matter of "geography, diet and culture" as related to the origins of appendicitis is thus demonstrated to be a myth. Appendicitis may be clearly recognized as a problem of public health. Better understanding of the functional behavior of the vermiform appendix should bring physicians as well as other patients with appendical colic to the operating table much earlier.

1. Piersol, G. M., and Bortz, E. L.: The Aging Process: A Medical-Social Problem, Ann. Int. Med. **12**: 964 (Jan.) 1939.

1. Wangensteen, O. H.: The Genesis of Appendicitis in the Light of the Functional Behavior of the Vermiform Appendix, Proc. Inst. Med. Chicago **12**: 266 (Feb. 15) 1939.

EFFECT OF ACIDIFIED CANDIES ON TEETH

Freshly extracted teeth were used by West and Judy [1] in experiments designed to test the destructive action of solutions made from acidified candies on the dental enamel. The teeth were mounted singly in rubber stoppers by embedding the roots in beeswax followed by a coat of acid proof paint. Only sound enamel was exposed. The teeth were then subjected to solutions of varied strength of acidified candies in water, these solutions showing high acid reactions with p_H values ranging from 2.5 for the strong solutions to 5.4 in some of the 20 per cent solutions in normal saliva. The destruction of enamel was greater the lower the p_H of the solution and the longer the period of exposure. It was pointed out in the discussion that, when a person places a piece of ordinary acidified candy in his mouth and allows it to dissolve slowly against his teeth, the concentration of the solution at the surface of the candy and in contact with the tooth enamel will be high with a probable p_H of from 3 to 4. If repeated at frequent intervals, the experimental data would indicate that serious decalcification is likely to result. Although the buffering action of the saliva in the mouth, where it is being continually secreted, is undoubtedly more efficient against acidified candies than in the experiments reported, the teeth treated in the experiments under conditions that lead to solution of tooth enamel showed a chalky insoluble layer on the surface which could be easily scraped off. The calcium phosphorus ratio in this material was high, owing to the exchange of citrate ion of the solution for the phosphate ion of the enamel. These investigators, therefore, are of the opinion that this phenomenon of ionic exchange between tooth enamel and acidic groups of various foods may be an important factor in the general process of tooth destruction throughout the years of tooth life.

1. West, Edward S., and Judy, Frederick R.: Destruction of Tooth Enamel by Acidified Candies, J. Dent. Res. **17**: 499 (Dec.) 1938.

ORGANIZATION SECTION

ABSTRACT OF HEARINGS ON THE WAGNER HEALTH BILL

(Continued from page 2539)

(Additional hearings before the Subcommittee of the Committee on Education and Labor.)

STATEMENT BY DR. THOMAS PARRAN

Dr. Thomas Parran, Surgeon General of the United States Public Health Service, stated that the Wagner Health Act is a logical outgrowth of the Social Security Act and the most comprehensive approach ever made to the diverse and serious problems of health and medical care for the nation. He felt that the bill very wisely proposes the grant in aid system, saying that "this is such a well established part of our governmental structure that it seems unnecessary for me to defend the principle." He then discussed the health condition of the nation, pointing out that death rates are not a measure of national fitness; neither do death rates give an indication of the economic burden which disability creates among the low income groups in our population. He said that less than one third of the counties and even a smaller proportion of the cities employ full-time professional health officers. Concerning the distribution of physicians in hospitals he said:

We have in this country some 160,000 physicians in active practice—an average of one physician to 807 persons. But in certain of the predominantly rural states—the Dakotas, Mississippi, North and South Carolina—each physician serves an average of 1,300 persons or more. In Kentucky, one physician serves an average of 1,106 persons in the state as a whole, but in nine counties of the state the average population per physician is 3,000 or more. The situation in Kentucky is not an isolated example; internal variation of a similar nature may be observed in the predominantly urban states. New York State is, on the average, well supplied with physicians; yet a few years ago in its largest cities there was an average of one physician to 535 persons, while in its small towns and villages the ratio was one physician to almost 1,000 persons. These figures illustrate a general trend—the tendency of physicians to concentrate in the large urban centers, which, through their hospitals and clinics, offer opportunity for the application of modern medical technic.

Your committee has heard very divergent points of view concerning the hospital situation in the country. It has been stated, for example, that an average of 195,674 beds in existing institutions are empty. I would point out, first, that no hospital can operate at 100 per cent capacity. From 80 to 85 per cent bed occupancy is considered full capacity for general hospitals because of the necessary division of wards and sections by sex, disease, and so on. For example, a temporary surplus of beds in the obstetric ward cannot be used for the care of measles or scarlet fever. Medical and surgical conditions cannot be mixed. In some areas the color division further complicates the problem.

The most determining point, however, is the lack of ability of patients to pay for hospital care. The data show that the public hospitals, which by and large are free, are more than filled to capacity, while private rooms in voluntary and proprietary hospitals remain empty. There is an anomalous situation in the fact that in many areas which have the lowest number of hospital beds per capita there is the highest percentage of unused beds. Lack of money, not lack of patients, keeps them empty.

Even a small subsidy to free care of patients in hospitals is of great assistance in securing medical care for the poor. Some of you may know that in North and South Carolina the Duke Endowment started some years ago to provide a subsidy of $1 a day for each free patient in approved hospitals of those states. When this work was started only nine patients in every hundred being treated in the hospitals of the Carolinas were free patients. As a result of this subsidy of $1, today the percentage of free care has risen to 45, a fivefold increase in the number of needy patients who have been given needed hospital treatment. The fivefold increase in free patients is made up largely of those who previously went without care simply because the hospital could not afford to admit them.

Senator Murray:—How is that subsidy provided that you described there?

Dr. Parran:—It is provided by the Duke Endowment, whereby any hospital which meets standards which they have prescribed, reasonable standards as to records and physical conditions in the hospitals—

Senator Murray (interposing):—I did not catch the word "Duke" at first. I thought it was some other organization.

Dr. Parran:—It is the Duke Endowment.

The bill under consideration proposes to use public monies, federal, state and local, to pay for the care of needy patients in existing public and private hospitals.

Senator Murray:—Was there not an understanding that it would not apply to the private hospitals?

Dr. Parran:—Quite the contrary, Mr. Chairman. The use of public monies is contemplated under this act, and particularly under titles I, III and VI, to pay for the care of needy patients in existing public and private hospitals. Under title XII it was not contemplated that public monies would be used in the construction—to assist in the construction of privately owned hospital facilities. It is perhaps on that point that the misunderstanding has arisen.

Under this bill, every available bed would be utilized before additional hospitals would be built. Even when this is done, however, there still remains a need in many areas for additional beds. There are 1,338 counties containing about 17 million people in which there is no registered hospital. Obviously each of these counties does not need a hospital. We have estimated, however, that we do need about 500 rural hospitals. Many of these would replace present tumble-down shacks. As a matter of fact, the experience of the Commonwealth Fund in aiding the construction of rural hospitals has shown that, of some 1,300 or 1,400 hospitals which they have aided, in every instance but one, one or more existing so-called hospitals has been closed up—fire traps frequently, very inadequate facilities, and totally inadequate to meeting the needs of the community.

Senator Murray:—Doctor, would not a great many of these so-called fire traps that you have mentioned, would the communities not be glad to rebuild their hospitals or build new hospitals if they have the financial aid to do it?

Dr. Parran:—Most of them would, yes, sir, without a doubt, and that has been the experience of the Commonwealth Fund in giving aid to communities which have asked for assistance.

Senator Ellender:—Doctor, with respect to the assistance to be given to needy patients, there has been quite a lot of testimony to the effect that this bill does not make the difference between the indigent and those who could afford to pay. Can you point out in the bill wherein that would apply, that no distinction is made between the needy and the indigent?

Dr. Parran:—Senator Wagner has emphasized that very point, Senator Ellender, on a number of occasions. The bill does use the words "particularly in rural areas and among needy persons." The bill contemplates primarily the giving of aid for the medically needy, but then the question arises How is it possible in any federal legislation to define the medically needy? Very wisely that definition is left to the state. Moreover, under title XIII as now written, it would be possible for a state if it wished to pass appropriate state laws and tax itself, or to provide free insurance contributions, to give medical care to persons who are above what we call the marginal level. The bill does not prohibit it; it does not, however, coerce the states to do it.

A mere statement of the number of hospitals does not indicate the adequacy of hospital facilities. This is well illustrated by the general hospital situation in the states of the South in comparison with those of the Northeast. Each section contains about 30 per cent of the total population of the country and each is served by approximately the same number of local general hospitals, 1,217 in the Northeast, 1,177 in the South. But the bed accommodations in these hospitals of the Northeastern states total some 157,000, in the South only 67,000.

[Dr. Parran then discussed distribution of hospitals for the tuberculous and for the mentally diseased, stating that twenty-six states have less than one bed per annual death from tuberculosis. For the mentally diseased the state with the highest ratio of beds has 6.88 beds in mental institutions per thousand persons, whereas the lowest ranking state has 1.96 beds per thousand of population. He asserted that 130,000 new beds would be required to bring the remaining states up to the standard of 4.8 which one fourth of the states now meet or exceed. He then continued:]

In the case of local general hospitals the number of available beds varies among the states from 1.3 to 5.5 per thousand of

population. Professional judgment indicates that an average of 4.5 beds per thousand must be maintained to provide adequate facilities of this type. It is proposed that the states falling below this average should be aided in building additional hospitals when needed by provision of state and local funds to match the federal assistance. Only three states at present exceed this standard, and it is estimated that 180,000 additional beds in general hospitals will be required to bring all states up to the accepted standard of adequacy. I think it would be well to point out also that these estimates were based on a ten-year program of construction, during which the population inevitably will grow somewhat, and moreover it obviously rests with the Congress from year to year to make such appropriations as are shown to be needed by the actual shortage of facilities in the various states. It may be that there is an excess of hospital beds in some states or some parts of states. The difficulty is, however, that we may not move the beds and it is impracticable to move the patients over long distances.

Two generations ago the only function of a hospital was to serve as a place where the sick poor could go to die. With the development of modern medicine they have become a vital force in health conservation. Decade by decade utilization of hospitals has increased. This trend is apt to continue and it will be intensified by the increasing average age of the population, since older people on the average suffer more sickness.

Senator Taft:—Doctor, may I interrupt you, because I have to go to the Appropriations Committee. On the question, the general question as to whether the bill permits the use of money to pay for beds in private hospitals, you would be in favor of having the bill permit that?

Dr. Parran:—The bill very specifically does permit the payment of a per diem or some other basis for care of patients equally in private voluntary and religious hospitals as it does in public hospitals.

Senator Taft:—We can settle about the provision of the bill later, but you are in favor of that principle?

Dr. Parran:—Yes, I am. But the bill does not provide for public monies to aid in the construction of privately owned facilities.

We have had much discussion of the number of people in the country that need medical care. The statement of the committee has been misinterpreted. There are about 40 million persons in this country who are in families with a total annual family income of less than $800, income derived from earnings and relief. I quote this estimate from the report of the Interdepartmental Committee. It was based on the national distribution of consumer incomes and records of recipients of relief.

The committee has defined this group of 40 million persons as the "medically needy." Even on casual consideration, it is evident that the standard of living permitted an average family of four persons on an annual income of $800 or less allows small margin, or none, to pay for good medical care. A family at this income level may be self sustaining in respect to the basic necessities; it is, however, needy in relation to its requirements for good medical care. The family on relief is also "medically needy"; but its indigence extends also to food, shelter and clothing. The 40 million persons to which the committee refers are in families such as these, receiving relief or supported by marginal incomes.

It is evident that this entire group of 40 million persons will not require medical care during a year. Almost one half of the group will experience no sickness. But the committee has estimated that about 8 million cases of illness disabling for a week or more will occur in these low income families, "and under the conditions prevailing in 1935, about 2 million of these cases will receive no medical care."

The committee's estimate of the proportion of unattended illnesses in this group of the medically needy was based on the results of the National Health Survey. This survey, made by the Public Health Service in the winter of 1936-1937, employed the method of the house to house canvass, with which the service staff has had long experience. Its findings were analyzed under the direction of able statisticians with an acknowledged position of leadership in the field of morbidity statistics. The results of this survey are in general agreement with those observed in the peak years of prosperity by the committee on the costs of medical care under the chairmanship of former Secretary Wilbur. They are, furthermore, harmonious with the findings of the California Medical Association, which estimated a few years ago that 218,000 persons in the state of California alone were currently in need of medical care but not receiving it.

Medical care of this group differs as between large and small cities, and rural areas. Where relief has not broken down, public funds in the large cities meet some of the costs of medical care of the dependent for illness requiring treatment in hospitals. The ambulatory cases among the sick poor in metropolitan centers receive treatment in outpatient departments, which are, however, greatly overcrowded. But these organized facilities for care of the sick are less widely developed in small cities and rural areas, and governmental funds for their support are meager.

Private physicians provide much free care of the patients who come to them for treatment, but many patients receive no care because they are unwilling to ask for service when they cannot pay for it. This endeavor to balance a marginal budget by neglect of health is in part the cause of the high death and disability rates in this group. We have accepted responsibility in principle for public assistance to those otherwise unable to obtain food, shelter and clothing. We must accept also a community responsibility for medical care of those who cannot provide it out of their own resources.

This bill does not establish any system of compulsory health insurance nor does it require or coerce the states to do so. Very wisely, I think, it leaves a decision as to whether or not health insurance is to be adopted in any state to the state itself. It seems clear that one or another state may wish to adopt such a system, and it would seem quite illogical for the federal government to pass laws which would prevent a state from dealing with its medical problems in the way in which it wishes to do so.

Actual experience in some states will provide a sounder answer as to its usefulness than mere argument. In my opinion group payment of the costs of medical care, through taxation or insurance or both, for those groups of the population unable readily to pay the costs of such care for themselves, would be an important factor in any complete national health program.

Senator Ellender:—You would say that, under the bill, should a state desire to raise its pro rata amount of money so as to match with federal funds, that that could be done?

Dr. Parran:—Yes, sir.

Senator Ellender:—And you would not want that written into the bill that it cannot be done?

Dr. Parran:—I think it would be a very unwise policy for the federal government to interfere to that extent with the medical policies of the state which up to now have been reserved to the states, and which under this bill would still be reserved to the states.

[He then discussed work already done under the Social Security Act and the Venereal Disease Control Act, taking up next the subject of industrial hygiene.]

To reduce disability and premature death in our working population, to discover and correct physical impairments, forms an integral part of the entire health program. As an expression of this function, most of the states have organized industrial hygiene units; in twenty-eight states these units are under the direction of the state health department. In many instances these units are functioning with skeleton organizations. They need great expansion of their services. To accomplish this end is one of the important objectives of title VI of the bill. In those states in which industrial hygiene is administered by a department of labor or industrial commission, funds will be allotted for their use. It seems very unwise to complicate further the administrative provisions of the bill by creating a separate title and separate administration for industrial hygiene as has been suggested by witnesses before this committee.

If industrial hygiene needs a separate administration, why not school hygiene?

Why not dental hygiene? Why not mental hygiene?

I think one should realize that this whole effort to prevent and cure disease should be a unity effort. It is difficult to separate the interrelated parts. Public health is an individual and a family problem in the last analysis, and not a problem of school hygiene or industrial hygiene or mental hygiene or dental hygiene. I anticipate, if recommendations continue to be made before this committee for separate divisions, it may have the bill broken up into various absolutely unworkable sections. Every specialty in medicine might wish to have a separate title and separate administration, with utter chaos.

Senator Ellender:—We had two witnesses who testified, one from New York and one from Illinois, as I recall, and one from Michigan, too. The two from New York stated that industrial hygiene was operated under the labor department, and in Michigan under the health department. Is there any good reason for that? Is there any good reason why the state of New York should operate in that manner?

Dr. Parran:—It is a matter of historical development, Senator, and it would appear to me unwise for the federal government to attempt to dictate the practice in any particular state. It happened that New York was one of the first states to have a well developed department of labor, and the work started there. In the meantime, the—for instance, in Connecticut the labor department did not take up this subject and the health department did.

Senator Ellender:—In distributing funds for that purpose in those two states in contrast to Michigan, where it is under the health department, would you have the federal government or the state department to allocate the particular funds to its department, or would you let it be handled, let us say, under the health department of those states?

Dr. Parran:—I suggest that title VI of the bill stand as written with respect to the industrial hygiene services, because under the provisions as now written the New York State Department of Industrial Hygiene in the Department of Labor would be enabled to secure funds allotted by the federal Public Health Service.

Senator Ellender:—Direct?

Dr. Parran:—Direct, subject only to the requirement that funds allotted to some agency other than a state health agency need to be approved by the state agency.

Senator Ellender:—In other words, it could not be made even then in those states direct but had to be under the supervision, as it were, of the health department of that state?

Dr. Parran:—Supervision only to the extent of the approval of the plan, which I think on analysis you will agree is necessary, to have some balance. In New York State the school hygiene work is handled by the department of education; mental hygiene is handled by a separate department of the state government. If there were no control as to the balance between industrial hygiene, mental hygiene, school hygiene and general public health work, I think it is quite obvious that each of these unrelated problems would put in its budgets and plans, and each one would want all the money that is available and leave nothing for the other fellow.

Senator Ellender:—As a matter of fact, and I would say in any event, the budget would have to come from the state health division, would it not?

Dr. Parran:—It would be approved by the state health division.

Senator Ellender:—And it would have to be passed on finally by it, would it not, because, as I understand it, under this bill the allocation of funds would have to be done by and with the consent of the health officer of a state?

Dr. Parran:—Yes. Well, what is the alternative? Earmark so much money for the industrial hygiene, create a special title, and earmark so much for school hygiene, for milk sanitation, and so forth?

Senator Ellender:—I am just wondering why it is that it could not be more uniform. Why that duplication, because you are bound to have duplication, let us say in the states of New York and Illinois—there may be some others for all I know—wherein money for hygiene purposes is spent by one division under the labor department, and hygiene work under the health department for some other purposes.

Dr. Parran:—You are quite right; and yet we have seen a great diversity in state laws and practice not only in this field but in the tuberculosis. In some states, state tuberculosis hospitals are operated by a separate hospital board or a separate tuberculosis commission or a department of welfare or a department of health.

Senator Murray:—How many states have departments of industrial hygiene?

Dr. Parran:—Some thirty or thirty-one.

Senator Ellender:—Separate?

Dr. Parran:—They have divisions of industrial hygiene. In twenty-eight of them these divisions are operating under the department of health.

Senator Murray:—And in some of the states where they need it most, they have not got that department at all, isn't that true?

Dr. Parran:—If so, it is only a skeleton organization. These twenty-eight states have recently set up divisions of industrial hygiene and they have made a good start; they have gotten at least one or two trained persons in those divisions of industrial hygiene. They could be expanded, and their services could be expanded, and of course there would need to be new arrangements with the state department of labor which have factory inspection and that sort of thing.

Senator Ellender:—How many are there that have it under the jurisdiction of the labor department? I named two—New York and Illinois; do you know of any others?

Dr. Parran:—My best information is that there are three; one additional state besides those two.

The provisions of this bill would give responsibility to the Children's Bureau for medical care of children, to the Public Health Service for medical care of certain high cost illnesses (tuberculosis, cancer, pneumonia, venereal disease) and to the Social Security Board for medical care of persons other than children and for diseases other than those for which the Public Health Service is given responsibility. Rather than complicate further the administrative dispersion of responsibility among several unrelated agencies, I urge that the first objective of the bill be to coordinate federal health service.

We can never attain national health and fitness simply by money grants out of several federal pockets with no correlation between them, no joint planning, no uniform standards, and with diverse budgetary requirements, systems of reports, triplicating field staffs to deal with the states, and audit accounts.

Senator Ellender:—Well, doctor, in that connection, there was a witness, as I recall, who testified that quite a lot of this work was being done here in Washington under the federal government in the various departments of the government. Would you have any views on that? In other words, you talk about coordination; I wonder if we could not begin that at home here?

Dr. Parran:—I urge that as the first objective of the bill. As the head of one of the government bureaus, I feel somewhat reluctant to make a specific recommendation particularly in view of the reorganization act under which the President continues to have authority further to coordinate the health services of the government, and I may say that in my opinion, reorganization plan No. 1 was a fine step in the right direction in bringing health education and the social security board, among others, together.

Senator Ellender:—Have you studied this reorganization to find out whether or not the president could without legislation from the congress coordinate these departments that you have in mind?

Dr. Parran:—That authority does exist in the bill. Public health measures for the prevention of disease—my plea is that this bill should not further create confusion and further disperse the present unrelated and scattered federal health activities, and for these reasons: public health measures for the prevention of disease merge naturally with medical service for the advance in treatment of disease. The Public Health Service has had a background of dealing with the states for almost fifty years. We have had no difficulty in administering title VI with the states; there has been no suggestion of federal domination and federal control. There has been, I think, one of the finest examples of federal and state cooperation in administering title VI, and I may say also title V of the Social Security Act.

Accordingly, I urge specifically with respect to Senate 1620 that the adminstrative agency under title XIII be changed from the Social Security Board to the Public Health Service. To promote coordination and joint planning between the several federal agencies—if it is impossible to bring them entirely together—agencies which are administering services under this bill, I recommend that the bill be amended as follows: (1) To provide reciprocal provisions requiring the Public Health Service and the Children's Bureau to establish systems of uniform budgeting, accounting and reporting by state agencies; (2) to provide that rules and regulations regarding payments to states under Sections 504, 514, 604, 1204 and 1304 shall be harmonious and made after joint consultation by the Public Health Service and the Children's Bureau, with a joint conference of the state and territorial health authorities or with the executive officers of other state agencies charged with the administration of services under this act; (3) to provide for a single Federal Advisory Health Council composed of members of the professions and agencies concerned with the promotion of health and medical services and other persons informed on the need for or provision of health and medical services, in place of the several federal advisory councils provided for in sections 506, 516, 606, 1206 and 1306; a great multiplicity of councils exists.

Senator Ellender:—How would you select them, doctor?

Dr. Parran:—If the Children's Bureau and the Public Health Service are the only two agencies dealing with the health and medical aspects of the bill, it would be very simple to have a council of seven, three, let us say, appointed by the—by each of the agencies, and the seventh the chairman of the state and territorial health organization ex officio.

Senator Ellender:—What would be the jurisdiction of that council?

Dr. Parran:—As provided under these several sections. They are advisory councils supposed to advise with respect to the rules and regulations and with the general policies.

Senator Ellender:—Would you have a separate council for each subdivision?

Dr. Parran:—I would have only one for the titles V, VI, XII and XIII.

Senator Ellender:—And another for what?

Dr. Parran:—That is all.

Senator Ellender:—That would be one council; in other words, the council that you suggest would have jurisdiction over the entire works, as it were?

Dr. Parran:—It would replace an unknown number, certainly five councils which are now required under this bill.

Senator Ellender:—How would that be worked in the states, let us say? Would you recommend the same thing, that, instead of having different councils in the states, there be one council in each state?

Dr. Parran:—I hope that the bill would not require additional councils. One or another state would wish to have more, but I hope that the emphasis in the bill would be toward similar joint planning through one council. I am not prepared at the moment to say that I would go so far as to say that there must be only one. Again I think we should leave the states the greatest of freedom.

Senator Ellender:—Your recommendation would be then that one council would be sufficient?

Dr. Parran:—This is a health problem, and that is a unit problem by and large.

Senator Murray:—And a multiplicity of councils would be sure to promote conflicts and different ideas, would it not?

Dr. Parran:—I do not see how it could be avoided.

Senator Ellender:—You would have quite a lot of jealousies among the councils as to whom the money should be allocated, how it should be allocated and all of that? I think your objection is very good and, by the way, one of the witnesses I think testified that 268 or some such number of councils would be organized throughout the country and I believe if we can limit it to one from each state, that is suggested as it were to the states, and have it obligatory so far as the federal government is concerned, that it would be doing very well.

Senator Murray:—Sometimes it is difficult enough to get cooperation with even one council, like the TVA where we found great difficulty.

Senator Ellender:—Doctor, what would be your suggestion as to how the council should be selected in the states?

Dr. Parran:—The state agencies responsible for the administrating or the administering of the several parts of the program should meet on the makeup of the council or, if there is this agreement among them, it should be possible for the governor to straighten out any interdepartmental bickering as to relative jurisdiction.

Senator Ellender:—What if we suggested — it is only a suggestion and we do not want to make the states do it — but as far as we could — there was a witness here who testified that in the state of Kentucky the medical association selected members for certain positions in the boards, and so forth, created under the state law. What would be your view on that?

Dr. Parran:—As I have observed its workings in Kentucky and Alabama, and I think South Carolina, there are three states in which that is the pattern. No other states saw fit to establish the same pattern when their boards were started many years ago.

Senator Ellender:—How has the plan worked in the three states that you have just mentioned?

Dr. Parran:—It seems to have worked well.

Senator Ellender:—Do you know what caused a change in those three states?

Dr. Parran:—There was no change; it was a matter of the original setup back in the days when there were yellow fever epidemics, and these boards of health were organized to meet them. The medical associations were turned specifically to organize the boards in these states and given certain authority under the law. No other state has seen fit, however, to invest responsibility for the health of all the people in one professional group.

Senator Ellender:—You say that so far as the council is concerned here in Washington you would suggest that each division make its own selection or each department?

Dr. Parran:—Joint action.

Senator Ellender:—What if you put them all under one, as we have just been talking about?

Dr. Parran:—As the head of one federal bureau having very harmonious relations with the Children's Bureau, which under the laws going back to 1912 give it certain responsibility for the public health, I think it would be most inappropriate for me to make any suggestions on that score, especially in view of the fact that the Congress has never seen fit to change that setup.

Senator Ellender:—I won't put you on the spot. (Laughter.)

Dr. Parran:—I may say, Mr. Chairman, that in my own experience as Surgeon General we have had nothing but the finest cooperation with the Children's Bureau, and on many occasions we have seen to it that duplication is minimized and that we do work together in the most efficient possible way.

Senator Ellender:—While you are on the subject, how have your relations been with the states?

Dr. Parran:—With the state health departments?

Senator Ellender:—Yes; the various states of the Union.

Dr. Parran:—Dr. McCormick, the state health officer of Kentucky, gave some testimony on that subject speaking for all of the state officers. I subscribe fully to what he said in emphasizing that it has been possible to expend the funds, $8,000,000 a year under title VI, and now another $5,000,000 a year under the venereal disease act and $600,000 under the national cancer act, without any suggestion or complaint from any responsible source concerning unreasonable federal dictation or domination or coercion of the states.

Senator Ellender:—Under the Social Security Act as it is now drafted, most of the plans are really submitted by the states, are they not?

Dr. Parran:—All of them are.

Senator Ellender:—Have you ever actually turned them down and said "We don't want it this way; you must do it that way"?

Dr. Parran:—We have never turned down any whole state plan. As a matter of fact, they are worked out usually in consultation with our representatives, representatives of the Children's Bureau and their own people.

Senator Ellender:—Did you ever attempt to try and have them the same in one state as they have in another, as has been charged?

Dr. Parran:—Quite the contrary. And one of the criticisms so often repeated about this bill is that its provisions are indefinite. That statement has come up time and again in these hearings.

Senator Ellender:—Yesterday on four occasions.

Dr. Parran:—What is the alternative of that? A plan under which the federal government would regiment every township and county health officer and city council into a uniform pattern? I hope not. Another criticism has been made that this bill gives to the federal government unlimited authority and unlimited discretion. If there are ways in which this committee can limit the discretion and the authority in the allotting of money to the states in order to put those allotments on a more objective basis, I should welcome very much such restriction. I should like to point out, however, that the language of this bill restricts my authority much more than the language of the present title VI or the venereal disease control act.

Senator Ellender:—Yesterday or the day before — last week I think it was — one witness said "The first year you are going to spend so much; the second year you are going to spend so much; the third year you are going to spend so much, and the fourth year it is unlimited; think of such a statute as that." They forget that we have to go to the Congress, to some of these hard-boiled senators and congressmen, and have got to show them the necessity for it before they appropriate.

Dr. Parran:—I am sure, Senator, that those people have no concept of the amount of factual data, the extent to which actual need must be demonstrated before the appropriations committees of these two bodies before any monies are appropriated, and especially before any increased monies are given.

Senator Ellender:—If they were to appear before those committees once or twice, they would be convincted of that.

Senator Murray:—Those in favor of balancing the budget laugh away such a thing as that when it is suggested. They think that the opportunities for getting appropriations are unlimited and that all we have to do is to go in and ask for it and that we get it.

Dr. Parran:—In connection with balancing the budget, Mr. Chairman, I hope that this congress will give more attention to balancing our health budget. It is cheaper to keep a woman from dying in childbirth than to take care of the orphans in an orphan asylumn or to give aid to the dependent children. It is cheaper to aid in building tuberculosis sanatoriums than it is to pay for the deaths from tuberculosis and the widows and children who are left. The state health officer of Tennessee made a statement the other day which impressed me very much. He estimates that it costs on the average $150 to bury a person in Tennessee, and on that basis it is costing that state more to bury people dying from tuberculosis than it spends for its entire health program including tuberculosis and all the other diseases.

Senator Murray:—So that money invested in this manner would be wisely invested and would tend to an ultimate balancing of the budget?

Dr. Parran:—It would be a direct economy. I don't know of any more economical expenditure of public funds than those spent wisely for health protection and health promotion.

The provisions of the bill regarding variable grants in aid are believed to be well conceived. They should insure allotments of money only to meet demonstrated health needs. If the poorer states are to have adequate health programs, it is essential that the federal government contribute a larger share of each dollar expended in these states than in the states having greater

economic resources. Under title VI of the present Social Security Act, the Public Health Service has been enabled to allocate funds in part from the financial and special health needs of the states. For example, the per capita allotments budgeted by the states from federal funds under this title for the present fiscal year vary from 5 cents to 41 cents.

Finally, may I say, Mr. Chairman, that this is not a measure to socialize medicine in the country. Quite the contrary; it is a measure which will free medicine to render better service to all the people. It proposes to share, to socialize more of the costs of medicine, but not to socialize medicine. The objectives of the bill can be attained without any basic change in the practice of medicine in this country.

Senator Ellender:—Doctor, how would the passage of this bill, let us say, and making it effective, affect the pocketbooks of the doctors?

Dr. Parran:—Obviously the $50,000,000 proposed to be allotted the first year under title XIII for the care of needy patients would go in large part to the physicians as well as to existing hospitals. Some of this great load of charity which the doctors carry and under which many of them are staggering would be lessened.

Senator Murray:—Doctor, during the serious conditions under the depression, is it not a fact that in many sections of the country many of the doctors were kept in practice by the moneys that they received through grants from the relief organizations?

Dr. Parran:—It is quite true, and it is still true, Mr. Chairman, that in many rural sections the only thing that enables the doctor to buy his gasoline or pay his office rent is the little money that he gets from current relief funds for the care of indigent patients.

Dr. Parran then discussed dental hygiene and the effects of the Wagner Health Act on the drugless healer. He also described the work of the United States Public Health Service and the manner in which the United States Public Health Service has cooperated with various state and county medical societies, with the American Medical Association and the medical schools. Special attention was also given to the problems of silicosis and malaria.

Senator Murray:—Well, doctor, we appreciate your testimony and hope that we may continue in contact with you during the further study of the problem. I am satisfied from your statement that we are going along the right lines, and all we need to do is to make the necessary amendments and corrections to the bill to carry out the purposes that we have in mind that you have so well expressed this morning.

Dr. Parran:—Thank you very much, Senator.

May I say just another word and thank you for the opportunity to be here? I was told this morning that the chairman of the subcommittee made a statement yesterday to the effect that he did not expect any final action of Congress on this whole bill at this session of the Congress. May I urge that at least the next step or two will be taken in regard to these matters, which are not controversial, and in regard to which there is great and obvious need? By so doing, we can begin to build up toward the whole program of public health if it is not possible to proceed on all fronts at this time.

Senator Ellender:—The great difficulty in separating it is that you separate the easy ones from the hard ones and leave the hard ones out, and if you do that you may never get the hard ones through.

Dr. Parran:—I had not thought of that.

Senator Murray:—They are talking about adjourning by the 15th of July, doctor, and there are so many other bills ahead of this that it seems to me impossible to get this bill reported, because it will take time, considerable time, to transcribe this testimony and have it printed and then act on all of the amendments that are going to be considered; and then we want to give full consideration and study to every proposal that has been made, every criticism that has been made against the bill, and it would seem to me that it would be utterly impossible to give the proper consideration to the bill and get it up on the floor at this session.

Dr. Parran:—I can realize those very great difficulties.

Senator Murray:—I would like to see it done, if it is possible. If we had started earlier it might have been possible, but when we are in the present situation that we are now, and the testimony not yet concluded, I do not see how it is going to be possible.

Dr. Parran:—Thank you very much.

STATEMENT BY ARTHUR J. ALTMEYER

Mr. Arthur J. Altmeyer, chairman of the Social Security Board, described the work of the Social Security Board and the Interdepartmental Committee to Coordinate Health and Welfare Activities, stating that the Social Security Board has already endorsed the principal objectives proposed in S. 1620. He considered particularly the new functions given to the Social Security Board under titles 13 and 14 in the Wagner Health Act. Mr. Altmeyer again cited the 40,000,000 persons in the United States with incomes of less than $800 a year and stated that there were 21,000,000 persons with families dependent in whole or in part on local, state and federal governments for food and shelter and likewise dependent on private aid or philanthropy for medical care in sickness. An additional 20,000,000 he included in a marginal group which can purchase medical care only at the risk of curtailing food, clothing and shelter. He also stated that this is left only to local responsibility now and that medical care for this marginal group was inadequate. Mr. Altmeyer again made the statement so frequently used by Miss Josephine Roche that no one at the National Health Conference took exception to or raised a question concerning the picture of unmet needs. He felt that under title 13 states can develop plans to level the economic barrier by distributing costs among large groups of persons and over periods of time, saying "whether the states choose to do this through tax supported service, through social insurance or through a combination of the two, is a matter for them to decide." He also said that he did not think this would interfere in any manner with the medical profession as it operates now and that such changes would benefit the medical profession financially. Quoting:

Mr. Altmeyer:—Yes, financially, and I think professionally. I see no reason why the introduction of a systematic provision for spreading the cost of medical care not only should protect the services that we have now, the quality of the services that we have now, but would advance it. It all depends on how the thing is worked out. That is the job of an administration always, to bring in the technical groups and to bring in the groups who are interested in the effect. Not only the consumers, but the producers. That is the only way that we can get proper administration, but all parties in interest have a right to express themselves and to help in the development of the administrative machinery and its working.

Senator Murray:—Many of us would hesitate to do anything or approve of any bill that would in any manner break down the medical profession, and I think that the testimony that you are giving is important from the standpoint of wanting to protect the medical profession in every way from having their profession broken down. If this could be done without necessarily interfering with the medical profession, but on the contrary benefiting it, I do not see any reason why it should not be done.

He then further analyzed the various sections of titles 13 and 14 of the proposed act.

Afternoon Session

STATEMENT OF DR. LESLIE R. BURDETTE

Dr. Leslie R. Burdette, president of the American Optometric Association, presented a statement on deficiencies of eyesight, pointing out that an urgent need exists that is not due to a lack of qualified ophthalmologists and optometrists but to a low economic status of a great portion of our population. He recommended that projects be approved for the purposes of providing an annual examination for all school children and that the service of optometrists can be utilized in industrial hygiene activities. Under title 13 of the act he recommended that a periodic eye examination should be part and parcel of the program to be inaugurated. He said that telescopic spectacles, pinhole spectacles, microscopic spectacles and cataract lenses have proved their value in rehabilitation of the adult and that children have been rehabilitated by the use of telescopic spectacles. He told how optometrists cooperate with ophthalmologists, saying "we cooperated with ophthalmologists by securing and referring to them for treatment the cases of pathology." He said that under the proposed bill the optometrists of the country should rightly be allotted that portion of the work which is particularly within their field.

STATEMENT BY MR. M. LUTHER DICUS

Mr. M. Luther Dicus, third vice president and chairman of the Committee on National Affairs of the American Optometric Association, said "The specific purposes of the suggestions with which I shall close this statement is to guarantee that the people of this country on the enactment of S. 1620 shall have a continuation of the professional services rendered by optometrists and that optometry shall not be excluded from the operation of the act, directly or by implication."

He reviewed the history of social security legislation and of optometry and suggested some amendments which would include optometry in various sections of the act.

He also filed a statement by William B. Needles, president of the Northern Illinois College of Optometry, discussing educational standards of optometry.

STATEMENT OF MR. HAROLD KOHN

Mr. Harold Kohn, national counsel, American Optometric Association, stated that the legislative body of the American Optometric Association will meet on June 25 and will make further suggestions relative to the act.

Senator Murray:—That would be very satisfactory. You may do that. As far as I understand it, there is no conflict between ophthalmology and optometry? Ophthalmology deals with the organic diseases, those which the ophthalmologist may find in the eye, and the optometrist does the mechanical work?

Mr. Kohn:—Determining the refractive error.

Senator Murray:—And some of the finest people in the country patronize the optometrist without ever going to the ophthalmologist at all, is that not so?

Mr. Kohn:—That is; 72 per cent of them, by actual statistics. If the examination discloses a condition requiring the attention of an ophthalmologist, they are immediately sent to them.

Senator Murray:—So that there is no lack of harmony between the two professions?

Mr. Kohn:—Generally speaking, absolutely not. Once in a while there is a little professional jealousy in small communities. That sometimes happens but that is very rapidly being overcome through interprofessional relationship committees of the Ophthalmological Association and of our association.

STATEMENT OF MISS KATHARINE LENROOT

Miss Katharine Lenroot, chief, Children's Bureau, Department of Labor, described the development of the Children's Bureau and stated that the amendments proposed in S. 1620 would build on the foundation previously laid.

With the exception of increased amounts authorized, and a broadening of the maternity care program and extension of medical care to other classes of children than those now covered, the only changes in the proposed bill relate to methods of allotting and paying funds, matching provisions, conditions of approval of state plans, provision for a federal advisory council or councils, and authority to make rules and regulations. Though the provision for medical care of children is included in part 2 of title V for certain administrative reasons, it would appear that similarity of the conditions of allotment, payment and approval of plans under parts 1 and 2 would make it possible for a state to submit a single plan for maternal and child health, including maternity care and medical care of children, provided that under state law the state health agency has jurisdiction in these fields or can develop working agreements with other state agencies now charged with such responsibilities under state law.

There are now twenty-six states that administer the crippled children's program through the health departments, and the others administer that program through other departments of the state government at the present time. In many states responsibility for medical care of children is in some state agency other than the state health agency.

It would appear to be of utmost importance that medical, nursing and hospital care, provided for women at childbirth and for children when sick, be under the same state and local agencies as those providing preventive services. Under part 1 of title V as amended in the pending bill the state health agency is given full administrative authority, as under the present provisions of title V, part 1 of the Social Security Act. Under part 2, though, for a period of five years other state agencies may administer medical services for children or services for crippled and other physically handicapped children, at the end of that time responsibility would be given to the state health agency and a single plan of service could be developed for all maternity and child health work within the state. Such a plan to coordinate these services under the state health agency seems to be highly desirable and entirely feasible from an administrative point of view.

She then presented a statement by Dr. Eliot showing the present provisions of title V, parts 1, 2 and 5, and the proposed amendments; also a statement from the Secretary of Labor, indicating the desire of the Labor Department to retain the Children's Bureau.

STATEMENT OF DR. MARTHA M. ELIOT

Dr. Martha M. Eliot, assistant chief, Children's Bureau, favors the bill as a means of expanding the work of the Children's Bureau. She gave a record of the work thus far accomplished.

STATEMENT OF MR. V. A. ZIMMER

Mr. V. A. Zimmer, representing the United States Department of Labor, stated that he is director of the Division of Labor Standards of the United States Department of Labor. He said that the Secretary of Labor and the department feel that it is very important that allotments for industrial hygiene activities belong in the state agency charged with the responsibility of regulating conditions of employment in industry. They objected specifically to the placing of such work under the state health agency. He stated that industry and hygiene is not a medical question but essentially an engineering proposition.

MEDICAL LEGISLATION

MEDICAL BILLS IN CONGRESS

Changes in Status.—S. 1021 has been reported to the Senate, proposing to extend the benefits of the United States Employees' Compensation Act to members of the Officers' Reserve Corps and of the Enlisted Reserve Corps of the Army who are physically injured while performing active duty or engaged in authorized training. S. 2353 has passed the Senate, proposing to authorize an appropriation not to exceed $375,000 for the construction, rehabilitation and installation at Carlisle Barracks, Pennsylvania, of a medical field service school and such utilities and appurtenances thereto as may be necessary.

Bills Introduced.—S. 2575, introduced by Senator Hill, Alabama, proposes that all reserve officers of the army of the United States who were called or ordered into active military service by the federal government for extended military service in excess of thirty days on or subsequent to July 1, 1928, and who suffered disability or death in line of duty shall be entitled to receive the same pensions, compensation, retirement pay and hospital benefits as are now or may hereafter be provided by law or regulation for officers of corresponding grades and length of service of the Regular Army. H. R. 6576, introduced by Representative Gross, Pennsylvania, proposes to authorize the Secretary of Agriculture, in the interests of the public health and as a relief to the dairy industry of the country, to prepare and cause to be published a series of articles and advertisements promoting the consumption of milk and derivative dairy products. H. R. 6723, introduced by Representative Mundt, South Dakota, proposes to enact a "Navigable Waters Anti-Pollution Act" to be administered under the direction of the Chief of Engineers of the United States Army under the supervision of the Secretary of War.

DISTRICT OF COLUMBIA

Change in Status.—S. 1805 has passed the Senate, proposing to establish a lien for moneys due hospitals for services rendered in cases caused by negligence or fault of others. The bill contains no provision for a lien in favor of a physician who renders services under similar circumstances.

SICKNESS UNDER INSURANCE

It is generally agreed that the average worker in the United States loses about nine days annually from sickness. W. D. Jenkins, chief medical officer of the South Metropolitan Gas Company, London, in a recent address said,[1] concerning insured British workers:

> In this country there are about 15,000,000 insured workers who, it is stated, in an average year lose 30,000,000 working weeks through sickness annually. This is equivalent to the year's work of some 600,000 people, or an average annual abstenteeism of ten days for men and twelve for women. It is true that these figures cover all grades of insured workers and do not represent illness arising solely among those engaged in industry. On the other hand, they do not cover absences of three days or less.

1. J. Roy. Inst. Pub. Health & Hyg. 2: 178 (March) 1939.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

ALABAMA

Outbreak of Gonococcic Ophthalmia.—A gonococcic infection was said to be the cause of a recent outbreak of thirty-nine cases of ophthalmia in a rural school having an enrolment of 140. Some of the patients were convalescent when first seen, but nine of the cases were proved to be due to the gonococcus. The disease was introduced into the school by a boy who had acquired the infection from an adult similarly infected. When all the pupils were examined for genital infection, none of the boys was found infected but seven small girls were found to have gonorrheal vaginitis.

ARKANSAS

Appropriation to Medical School Increased.—The Arkansas legislature recently granted to the University of Arkansas School of Medicine, Little Rock, an increase in its annual appropriation from $70,000 to $300,000. The increase was granted chiefly to enable the school to take over the Little Rock City Hospital, with a capacity of 200 beds, adjoining the medical school.

CALIFORNIA

Hospital News.—A contract has been let for a new wing, costing $225,000, at the Palo Alto Hospital; construction is to begin immediately.

Plague Infection.—Plague infection was proved in three ground squirrels, Citellus beecheyi, submitted to the laboratory of the state department of health April 18, from a ranch on Casitas Pass Road, Ventura County, 2 miles east of the Santa Barbara County line, according to *Public Health Reports.*

Society News.—Dr. Albert H. Rowe, Oakland, addressed the Butte County Medical Society in Chico on "Allergy and Its Manifestations" recently.——Dr. George Joyce Hall, Sacramento, discussed "Clinical Evaluation of Endocrine Therapy in Menstrual Disorders" before the Hollywood Academy of Medicine June 8.——The section on medicine and pediatrics of the San Francisco County Medical Society held a special meeting June 6 with Drs. Garnett Cheney and Jesse L. Carr speaking on "Clinical Application of Vitamin K" and "Laboratory Methods of Vitamin Determination (A, B, C, Nicotinic Acid, and Their Clinical Application" respectively.

CONNECTICUT

Personal.—Dr. Ross G. Harrison, Sterling professor of biology, emeritus, Yale University, New Haven, delivered the Linacre Lecture at St. John's College, Cambridge, England, May 16, on development of the internal ear, a study in experimental embryology.——A testimonial dinner was recently held in Bridgeport in honor of Drs. James D. Gold, chairman of the council of the state medical society, and Daniel C. Patterson, a recent president of the state board of medical examiners. ——Dr. Perry T. Hough has been appointed medical examiner in Hartford, succeeding Dr. Henry N. Costello.

Grant Supports Work in Biology.—Yale University has received from the Rockefeller Foundation a grant-in-aid of $189,000 toward the continued support of the Yale Laboratories of Primate Biology for the five year period July 1, 1939, to June 30, 1944, and also $35,000 for the construction of an additional laboratory building at the Anthropoid Station at Orange Park, Fla. According to *Science,* under the reorganization of the laboratories, following the ten year period for which the project was originally financed, the director, Robert M. Yerkes, Sc.D., will be responsible to an administrative committee, serving as a board of control. Members of this committee include Carl G. Hartman, Ph.D., research associate in embryology, Carnegie Institution, Johns Hopkins University School of Medicine, chairman; Edgar Alien, Sc.D., professor of anatomy at Yale; Leonard Carmichael, Ph.D., president of Tufts College, Boston; William H. Taliaferro, Ph.D., dean of the Division of Biological Sciences, University of Chicago; Dr. Yerkes, professor of psychobiology at Yale, secretary, and Dr. Stanhope Bayne-Jones, dean of the Yale school of medicine, member ex officio.

GEORGIA

Personal.—Dr. Charles L. Ridley, superintendent of the Macon Hospital, Macon, has been appointed a member of the state board of health, succeeding Dr. Allen R. Rozar, whose six year term expired some months ago, according to the *Modern Hospital.* Dr. William P. Harbin, Rome, has also been appointed a member.

Annual Clinic Week.—Emory University held its annual clinic week at Grady Hospital, Atlanta, May 30-June 2. The program included lectures, clinics and symposiums. One session was a joint meeting with the Fulton County Medical Society. At the annual banquet at the Henry Grady Hotel, Dr. Frank K. Boland Sr. was the guest speaker.

ILLINOIS

Hospital News.—The Commonwealth Fund has offered to contribute not less than $225,000 to build and equip a community hospital in Pittsfield, provided that the people of the area to be served raise an additional $60,000 by July 1, according to *Hospitals.*

Mosquito Abatement Campaign.—A survey to determine the cheapest way to destroy mosquitoes was decided on May 19 by the Tri-County Mosquito Abatement Committee, made up of representatives from Lake, DuPage and Cook counties, newspapers reported recently. When the plans have been completed they will be made the basis of a proposal for a WPA project, it was stated.

Chicago

Wanted—Patients with Essential Thrombocytopenic Purpura.—Members of the department of medicine of the University of Illinois College of Medicine are interested in the study of essential thrombocytopenic purpura. Patients with this disease will be accepted in the Research and Educational Hospitals without charge provided they are referred by their family physician. Letters should be addressed to the head of the department of medicine of the university.

Society News.—At a meeting of the Chicago Society of Allergy June 10, Drs. Isidor Harrison Tumpeer spoke on "A Dramatic Asthmatic" and Rudolph Hecht on "Sensitization to Simple Chemicals: Reactions to Commercial and Purified Lipstick Dye."——Dr. Leon Unger addressed the Chicago chapter of the American Physiotherapy Association June 7 on "Allergy in General."——Dr. Disraeli W. Kobak discussed "Advances in Short Wave Therapy" before the McDonagh Society for Clinical Research May 31.

INDIANA

Veteran Teacher Honored.—Dr. Alois B. Graham, professor of surgery (proctology), Indiana University School of Medicine, Indianapolis, was honored at a meeting in the James Whitcomb Riley Memorial Hospital May 8, marking his retirement from the medical school faculty after forty years' service. Dr. Graham was presented with a portable radio and a gold medal. He was president of the Marion County Medical Society in 1916, of the Indiana State Medical Association in 1929, of the American Proctologic Society in 1919, and chairman of the Section on Gastro-Enterology and Proctology of the American Medical Association in 1928. During the World War he served as chief surgeon of base hospital number 32 in France.

IOWA

Personal.—Dr. William O. Smouse, Des Moines, was elected a life member of the Iowa State Medical Society at its recent annual session.——Dr. John C. Dennison, Bellevue, recently completed fifty years in the practice of medicine.

Society News.—At a meeting of the Des Moines Academy of Medicine and the Polk County Medical Society May 23 Drs. Floyd A. Springer discussed "Treatment of Carcinoma of the Breast" and John W. G. Caldwell, "Diagnosis and Treatment of Coma."——Dr. Verl A. Ruth, Des Moines, addressed the Henry County Medical Society in Mount Pleasant recently on back injuries.——The Woodbury County Medical Society was addressed recently in Sioux City by Dr. Archibald F. O'Donoghue on "Injuries to the Spine and Pelvis."

Spotted Fever.—From May 20 to 27 six cases of Rocky Mountain spotted fever with two deaths were reported to the state department of health, according to the state medical journal. The youngest patient was a farm boy, aged 5, in Davis County, while the oldest was a farmer and trucker,

aged 57, in Van Buren County. Other cases were: Farm girl, aged 12, in Clarke County; carpenter, aged 52, Woodbury County; carpenter, aged 49, Boone County, and housewife, aged 25, Tama County. One of the deaths occurred in an Indian woman at the Sac and Fox Reservation in Tama County, from which locality six cases (with two deaths) were reported in the summer of 1937. According to the state medical journal, it is as yet uncertain whether the second fatality was caused by Rocky Mountain spotted fever or by overwhelming infection associated with a fulminating type of purpura.

KANSAS

Society News.—The Sedgwick County Medical Society was addressed recently by Drs. Frederick W. Matassarin on "Rose Operation: for Repair of Trigonal Muscle (Incontinence in the Female)" and James S. Hibbard Jr., "Surgical Treatment of Hypertension."

LOUISIANA

Committee on Industrial Health.—The Louisiana State Medical Society has organized a committee on industrial health composed of the following: Drs. Shirley C. Lyons, New Orleans, chairman; Edward P. A. Ficklen and William H. Perkins, both of New Orleans; William V. Garnier, Bastrop, and Isaac L. George, Baton Rouge.

Society News.—At a special scientific meeting of the Orleans Parish Medical Society with the Tuberculosis and Public Health Association of Louisiana May 22, Drs. Julius L. Wilson discussed "Tuberculin Testing in Public Schools"; Leon J. Menville, "X-Ray in the Early Diagnosis of Pulmonary Tuberculosis," and Edgar Hull, "Clinical Value of the Early Diagnosis of Pulmonary Tuberculosis." The society was addressed May 8 by Drs. Manuel Gardberg on "Treatment of Diabetes Mellitus"; Joseph O. Weilbaecher Jr., "Acute Spinal Epidural Abscess with Report of Four Cases," and Frederick F. Boyce, "Mortality of Thyroid Disease in a Nonendemic Area: An Analysis of 102 Consecutive Deaths, with a Special Note on the Liver Factor."

MASSACHUSETTS

Personal.—Leroy M. S. Miner, M.D., D.D.S., dean, Harvard Dental School, Boston, and former president of the American Dental Association, was recently awarded the Jarvie Fellowship Medal by the Dental Society of the State of New York; this medal is presented each year in recognition of outstanding contributions to the dental profession, according to the *New England Journal of Medicine.*

MICHIGAN

Hospital News.—A new $350,000 hospital at Petoskey, to be called the Little Traverse Hospital, was recently opened; Dr. Dean C. Burns is director.

Institutes on Tuberculosis.—The state department of health is sponsoring a series of institutes on tuberculosis control for public health personnel throughout the state, according to the state medical journal. The institutes opened May 15 and feature the medical aspects of tuberculosis control and the part played by the public health nurses. The diagnosis and treatment of the disease from the point of view of the sanatorium specialist is also being considered.

Changes in Health Officers.—Dr. Willard G. Beattie, Ferndale, has resigned as city health officer, effective May 15, to devote his time to private practice, it is reported.—Dr. Edwin H. Place, Midland, who has been attending the University of Michigan School of Public Health on a leave of absence, has resigned as health officer of Midland County. According to the newspapers, Dr. Place has accepted a fellowship for study in public health with the Kellogg Foundation of Battle Creek.

New County Medical Society.—The Van Buren County Medical Society, formerly affiliated with the Kalamazoo Academy of Medicine, has been organized as a separate entity with the following officers: Drs. William P. Bope, Decatur, president; Ronald W. Spalding, Gobles, president-elect; Charles Ten Houten, Paw Paw, secretary, and Arthur H. Steele, Paw Paw, treasurer. The speakers at the new society's initial meeting included Drs. Paul R. Urmston and L. Fernald Foster, Bay City, and William A. Hyland, Grand Rapids. A charter was granted to the woman's auxiliary at the same time.

MINNESOTA

Society News.—At a meeting of the Scott-Carver County Medical Society recently Dr. Edgar W. Bedford, Minneapolis, discussed "The Clinical Aspects of Gallbladder Disease" and Dr. Ames W. Naslund, St. Paul, "X-Ray Diagnosis in Gallbladder Pathology."——Dr. William de B. MacNider, Chapel Hill, N. C., gave a Mayo Foundation Lecture at the Mayo Clinic, Rochester, recently entitled "Concerning Tissue Resistance and Tissue Adaptations."

Special Lectures at University.—Dr. August Krogh and his wife, Dr. Marie Krogh, of the University of Copenhagen, were guests of the University of Minnesota Medical School, Minneapolis, for ten days recently. During their visit Dr. Krogh presented lectures and seminars on the following subjects: "Osmotic and Ionic Regulation in Animals," "Circulatory Adjustment to Posture in Man," and "Comparative Physiology of Respiration." Dr. Marie Krogh lectured on "Nutritional Problems in Denmark."

MONTANA

Railway Surgeons' Meeting.—The Great Northern Railway Surgeons' Association will hold its annual meeting at Glacier Park Hotel, Glacier Park, June 30-July 1. The tentative program includes the following speakers:

Dr. Cyril J. Glaspel, Grafton, N. D., Management of Traumatic Wounds.
Dr. Hiram E. Cleveland, Burlington, Wash., Repair of Tendons.
Dr. Howard J. Knott, Seattle, Wash., Rupture and Repair of an Ossified Tendon of Achilles.
Dr. James E. Reeder, Sioux City, Iowa, Emergency Ophthalmology.
Dr. Frederick A. Kiehle, Portland, Ore., Management of Opacities of the Cornea.
Dr. Charles B. Wright, Minneapolis, Coronary Disease Among Railroad Employees.
Dr. Herbert E. Wheeler, Spokane, Wash., Tetanus: Report of a Case Complicated by Lordosis.
Dr. Axcel C. Baker, Fergus Falls., Minn., Osteomyelitis.
Dr. George N. Pease, Portland, Traumatic Appendicitis.
Dr. Arthur N. Collins, Duluth, Minn., Traumatic Rupture of the Kidney.
Dr. Roscoe C. Webb, Minneapolis, Traumatic Rupture of the Normal Spleen with Delayed Hemorrhage.
Dr. Otto W. Scholpp, Hutchinson, Minn., Disability of the Knee Joint Following Injury.
Dr. Otto W. Yoerg, Minneapolis, Fractures of the Os Calcis.
Dr. Berton J. Branton, Willmar, Minn., Fractures of the Metatarsal Bones.

NEW YORK

Annual Conference of Health Workers.—The Annual Conference of Health Officers and Public Health Nurses will be held at Saratoga Springs June 27-29 and the New York State Association of School Physicians will meet June 26. Governor Lehman, Surgeon General Thomas Parran of the U. S. Public Health Service, Washington, D. C., and Abel Wolman, Dr. Eng., Baltimore, president of the American Public Health Association, will be among the speakers. At one session three men who have been members of the state Public Health Council for twenty-five years will review the council's work: Dr. Simon Flexner and Mr. Homer Folks, New York, and Prof. Henry N. Ogden, Ithaca. Other speakers will include:

Dr. Karl F. Meyer, San Francisco, Equine Encephalomyelitis.
Dr. John E. Gordon, Boston, Epidemic Problems in Virus Disease.
Earle W. McHenry, Ph.D., Toronto, Results of a Dietary Survey in Toronto.
Dr. Maxwell Finland, Boston, The Use of Sulfapyridine in Pneumonia.

Among those who will address the school physicians are:

Dr. Herbert W. Schmitz, Yonkers, The School and the Cardiac Child.
Helen M. Manzer, Ph.D., New York, Recent Trends in Health Education.
Dr. Charles H. Keene, Buffalo, The Physician Considers "Physical Fitness Tests."
Dr. Rudolph Ruedemann Jr., Albany, Combating Skin Infections of School Children.

New York City

Unlicensed Practitioner Convicted.—Frederick C. Zinke, a chiropractor, was convicted May 24 in the court of special sessions of practicing medicine without a license. He received a sentence of three months in the workhouse, with execution suspended.

Course on Eye Conditions for Lay Workers.—New York University announces that a course entitled "Survey of Eye Conditions" will be given during the summer session in cooperation with the bureau of service for the blind, New York State Department of Social Welfare. It is designed for workers

in education, social welfare, public health nursing and allied fields to present a background of the conservation of vision. Inquiries may be addressed to Mr. James Meyers, director of the course, School of Education, New York University, Washington Square.

County Library Report. — The library of the Medical Society of the County of Kings and the Academy of Medicine of Brooklyn recently reported that greater use was made of the library in 1938 than in the previous year. The number of readers increased from 16,570 to 17,055. The library received support from the general funds of the society, from numerous local societies that hold meetings in the county society's building and from other organizations. The library purchased 245 books and 855 volumes of periodical publications or back files. It received regularly 1,545 current serial publications.

The WPA Reports.—Included in the WPA projects in New York in 1938 were many concerned with health and medical services. Of a total expenditure of $157,659,628 of WPA funds for all purposes, $7,648,629 was used for projects sponsored by the department of health and $6,666,348 for projects sponsored by the department of hospitals. To the total WPA funds the city added $28,408,354 for materials, the state $409,306 and various federal departments $460,878. Among new buildings constructed was one hospital; seventy-seven hospitals were enlarged and improved. Included in health projects was the tuberculosis service, under which 162,984 visits were made to homes and 63,753 persons received x-ray examinations. More than 20,000 children from 1 to 6 years old are under care at the five centers of the Children's Health Service. The housekeeping service for chronically ill persons in their homes has a total of 3,200 cases under its care. Three thousand children monthly receive lip reading instruction. Workers have made 53,000 visits to follow-up patients with syphilis and gonorrhea who fail to return to health department clinics for treatment. Other workers are rendering aid to the sick in twenty-six municipal hospitals. The New York Tuberculosis and Health Association has sponsored a study making an analysis of the course of rheumatic heart disease from complete records of persons who have died. At Memorial Hospital studies in atomic physics and the biologic effects of radiation are being aided.

NORTH CAROLINA

Poliomyelitis Is Not Epidemic in North Carolina.—Dr. Carl V. Reynolds, state health officer, issued a statement June 12 denying rumors that poliomyelitis is epidemic in North Carolina. Actually the incidence of the disease in the state has been below normal for the year, Dr. Reynolds said. There have been eight cases in the period January to June 10 and five of those occurred between January and April. One was reported May 1 and another May 11. None of these is in an infectious stage. Only one case could be considered infectious, one that developed in Greene County June 1. North Carolina had an epidemic with 675 cases in 1935 and it is believed that that epidemic affords protection for the present. Dr. Reynolds advised that persons should not come out of infected regions into uninfected areas, but there is no reason for travelers to avoid North Carolina, he declared.

NORTH DAKOTA

Personal. — Dr. Alfred R. Sorenson, Minot, has been appointed city health officer succeeding Dr. John L. Devine, according to the *Journal-Lancet*.——Dr. Harvey J. Skarshaug, Fargo, has resigned as city health officer to engage in private practice in Colorado.

OHIO

Plan Museum of Health and Hygiene.—Plans for a museum of health and hygiene have recently been launched in Cleveland. A building at 8811 Euclid Avenue has been donated for the museum by Mrs. Francis F. Prentiss and a campaign for supporting memberships has been started. Dr. Jacob E. Tuckerman is chairman of a committee of the Cleveland Academy of Medicine for the campaign.

Alumni Reunion.—The annual reunion at the University of Cincinnati College of Medicine was held June 10. The morning was devoted to grand rounds at the Cincinnati General Hospital with Dr. Mont R. Reid on the surgical service, Dr. Albert Graeme Mitchell on the pediatric service and Dr. Marion A. Blankenhorn on the medical service. A banquet was held at the Netherland-Plaza Hotel in the evening with Dr. Carl A. Wilzbach, health commissioner of Cincinnati, as the speaker.

OKLAHOMA

New Health Officers.—Dr. Daniel E. Little, Eufaula, has been appointed health superintendent of McIntosh County and Dr. John W. Francis, Perry, of Noble County.——Dr. Waldo B. Newell Jr., Enid, has been appointed superintendent of health of Garfield County, effective April 1, succeeding the late Dr. William W. Gill, Enid.——Dr. Joseph Fulcher was placed in charge of the new clinic for the treatment of venereal diseases opened April 20 by the Tulsa department of health.

Society News.—Dr. George S. Baxter, Shawnee, discussed "Acute Appendicitis in Children" before the Pottawatomie County Medical Society, Shawnee, May 13.——The Garfield County Medical Society met with the Kay County society in Ponca City May 25 for a program on office gynecology presented by the following Garfield County physicians: Drs. J. Wendell Mercer, Julian Feild, Marion E. Sheets, Glenn Francisco, George O. Miles, Francis M. Duffy, Bruce R. Hinson and Frederick A. Hudson. All are from Enid.

PENNSYLVANIA

Society News.—Dr. Julia Faith S. Fetterman, Philadelphia, addressed the Delaware County Medical Society, Chester, May 11 on "The Effects of Cancer of the Uterus and Its Treatment on the Urinary Tract."——Dr. James Alexander Miller, New York, addressed the Northampton County Medical Society May 19 on "The Modern Approach to Diagnosis."——Dr. Joseph H. Barach, Pittsburgh, addressed the Mercer County Medical Society, West Middlesex, May 10 on "Newer Aspects in the Treatment of Diabetes." Dr. Barach addressed the Blair County Medical Society, Altoona, May 23 on "Newer Insulins and the Modern Treatment of Diabetes."

Philadelphia

Birthday Dinner for Dr. Coates.—A dinner in honor of Dr. George M. Coates, professor of otolaryngology, University of Pennsylvania School of Medicine, was held at the Warwick Hotel May 27 to celebrate his sixty-fifth birthday. Dr. James A. Babbitt was toastmaster and the speakers included Drs. Benjamin H. Shuster; Chevalier Jackson; Isadore Friesner, New York; Ralph A. Fenton, Portland, Ore.; Burt R. Shurly, Detroit; Joseph C. Beck, Chicago, and Harris P. Mosher, Boston.

Pittsburgh

Alumni Meeting.—The annual homecoming of the Medical Alumni Association of the University of Pittsburgh was held June 10. A portrait of the late Dean Raleigh R. Huggins was presented to the university by Dr. James D. Heard on behalf of the alumni and accepted by Dr. William S. McEllroy, the present dean of the medical school. Dr. McEllroy and Dr. Thomas B. McCollough were the speakers at a luncheon at the Pittsburgh Athletic Club.

RHODE ISLAND

Society News.—Drs. Jacob E. Greenstein, Providence, and Raymond E. Stevens, Rumford, addressed the Pawtucket Medical Association April 20 on "Treatment of a Series of Twenty-Five Cases of Pneumonia at the Memorial Hospital with Sulfapyridine."——At a recent meeting of the Rhode Island Society for Neurology and Psychiatry in Providence Drs. Hiram Houston Merritt, Boston, and Frances Cottington, now of Memphis, Mich., spoke on "The Diagnosis and Treatment of Epilepsy" and "The Present Status of Metrazol in the Treatment of Mental Disease" respectively.

SOUTH CAROLINA

Personal.—A silver service was presented to Dr. Leonidas M. Stokes, Walterboro, by the alumni association of the Medical College of the State of South Carolina during a meeting of the First District Medical Society in Walterboro in May. The presentation was made by Dr. James R. Des Portes, Fort Mill, immediate past president of the South Carolina Medical Association and president of the alumni association. Dr. Des Portes reviewed Dr. Stokes' contributions to the advancement of the college and the medical profession and other speakers were Drs. Douglas Jennings, Bennettsville, president of the state association, Charles R. May, Bennettsville, a former president, and Dr. Edgar A. Hines, Seneca, secretary-editor.

TENNESSEE

Regional Meetings.—The Middle Tennessee Medical Association met in Columbia May 25-26. Among the speakers were Drs. William R. Cate, Nashville, on "Auricular Fibrillation: Its Significance and Management"; Barney Brooks, Nashville, "Surgery of the Gallbladder"; Thayer S. Wilson, Gordonville, "Sulfanilamide and Sulfapyridine and Report of Its Use in Smith County"; Hollis E. Johnson, Nashville, "Diagnosis of Pulmonary Tuberculosis," and Eustace C. Mason, Quebeck, "Serum Treatment of Pneumonia." —— The West Tennessee Medical and Surgical Association met in Huntington May 25.——The Tennessee Valley Postgraduate Medical Assembly will hold its fifth annual meeting in Knoxville June 28-30.

TEXAS

Society News.—Dr. Howard K. Gray, Rochester, Minn., was guest speaker before the Texas Surgical Society in Fort Worth at its semiannual meeting recently on "Problems Encountered in Surgery of the Biliary Tract."——Dr. Lester W. Baird, Temple, among others, addressed the Bell County Medical Society in Temple recently on regional enteritis.——Dr. Alfred L. Ridings, Sherman, addressed the Grayson County Medical Society recently on "Danger Points of Thyroid Surgery."——Drs. Felix P. Miller and Francis C. Goodwin, El Paso, addressed the Tom Green Eight Counties Medical Society, San Angelo, in April on "Chest Surgery in Tuberculosis" and "Lateral Bone Traction in the Treatment of Scoliosis" respectively.

WASHINGTON

Hospital News. — A full length oil portrait of the late Dr. James Tate Mason, Seattle, who died shortly after he was made President of the American Medical Association in 1936, was presented to the Virginia Mason Hospital by the alumnae of the nursing school. The presentation was made at a banquet at the hospital May 27.

Society News.—Dr. Jay Arthur Myers, Minneapolis, was the guest speaker at the annual meeting of the Washington Tuberculosis Association June 1-3 in Spokane.——A symposium on tuberculosis was presented at the annual meeting of the Kings County Medical Society, Seattle, June 5 by Drs. Byron F. Francis and John F. LeCocq, Seattle, and John W. Skinner, Kirkland. Dr. Alexander H. Peacock has recently presented to the society a portrait of the late Dr. James B. Eagleson, who was active in the establishment of the society's library and of *Northwest Medicine*.

Outbreak of Typhoid. — Eighty-two school children and one teacher in the town and area surrounding Sequim have typhoid, the Associated Press reported June 10. State and county health officials and the Red Cross began mass immunization. Investigation of possible sources of the disease revealed that 200 buns left over from a traveling carnival had been donated to the school. Health officials said that the buns, which were buttered, had apparently been left for some time at room temperature. Another possible source was a salad for which potatoes had been peeled some hours before use and which might have been handled by a carrier, according to the newspaper report.

WEST VIRGINIA

Society News.—Dr. Walter E. Vest, Huntington, addressed the Boone County Medical Society, April 20, on "Socialized Medicine and Medical Aid to the Indigent."——Drs. Lawrence B. Gang and Isidore I. Hirschman, Huntington, addressed the Logan County Medical Society April 12 on "Familial Hemolytic Jaundice" and "The Incidence and Diagnosis of Carcinoma of the Lung" respectively.——Dr. Charles J. Barone, Pittsburgh, addressed the Monongalia County Medical Society, Morgantown, in April on "Prenatal Care and Common Complications of Pregnancy."——At a meeting of the Parkersburg Academy of Medicine in April Dr. Oscar Swineford Jr., Charlottesville, Va., gave an address on "Diagnostic and Therapeutic Problems of Allergy."

WISCONSIN

Personal.—Dr. Edwin H. Federman, Montello, has been appointed health officer of Eau Claire County.——Citizens of Kimberly gave a banquet April 16 in honor of Dr. Charles G. Maes, who has practiced in the village for thirty-two years, and changed the name of the street on which he lives to Maes Avenue.

GENERAL

Division of Venereal Diseases Issues New Folder.—The division of venereal diseases of the United States Public Health Service has just issued the third in a series of educational folders dealing with syphilis which are generally available at $1 per one hundred copies. The present folder is entitled "You Can End This Sorrow," and is concerned with the prevention of syphilis in prospective mothers and in newborn babies. It is well written, concise, suitably illustrated and certainly should be in the hands of every prospective mother.

Bequests and Donations.—Gifts and bequests of more than $20,000 to the James Whitcomb Riley Memorial Association have been reported, including $16,000 from the estate of Mrs. Atta R. Linthicum, Evansville, Ind.; about $1,000 from the estate of Mrs. Emma Herpick, Indianapolis, half of a $3,500 bequest left jointly to the memorial association and the General Protestant Orphans' Association by John G. Lehr, Indianapolis, and a bequest of $8,000 from the estate of Ira Williams, Anderson, subject to the settlement of litigation brought to construe the will. It was also announced that John W. Bradford of Morgan County had given his $75,000 home and 900 acres of land to be used as a convalescent unit of Riley Hospital or for some similar purpose; the gift was made to Riley Hospital and Indiana University.

CANADA

Rural Health Conservation Awards. — The St. Jean-Iberville-Laprairie-Napierville county health unit received the first award in the second rural health conservation contest conducted by the Canadian Public Health Association in cooperation with the American Public Health Association. This four-county unit also won the award in the 1937 contest. Nine awards of merit were conferred on other units.

Government Services

Medical Phases of Social Security Administration

The Social Security Board in its report for the fiscal year ended June 30, 1938, states that the Children's Bureau of the U. S. Department of Labor made grants of $3,728,930.58 from funds provided by the Social Security Act to state and territorial agencies for maternal and child health services and $2,694,676.33 for services for crippled children.

Fifty-one plans were submitted by states and territories for maternal and child health services. More than half the funds in the fiscal year 1936-1937 were used to provide public health nurses; about 1,000 new ones have been placed in the field. Reports of state health officers for the calendar year 1937 showed that physicians made 1,405,807 health examinations of school children. Office and home visits by public health nurses included 880,691 for maternity nursing, 1,092,188 for infants, 945,616 for preschool children and 2,975,790 for school children. Reports showed 898,506 diphtheria immunizations and 1,078,779 smallpox vaccinations.

Fifty jurisdictions are now receiving funds through the Children's Bureau for services for crippled children. The total number of children on the state registers of forty-six states, Alaska and Hawaii as of June 30, 1938, was 151,909.

The U. S. Public Health Service with an appropriation of $8,000,000 for grants-in-aid has enabled states to strengthen their health organizations along the following lines: promotion and supervision of local health services, public health engineering, control of preventable diseases, laboratory facilities, dental hygiene, vital statistics and public health nursing. Thirty-three states now have special units for control of venereal disease; twenty-five have instituted measures for control of tuberculosis; eight have active programs to decrease pneumonia mortality; six others have organized an attack on cancer. More than 3,000 persons have received special graduate training in public health work.

The third agency concerned with welfare services under the social security program is the Office of Education, which administers the program for rehabilitation of the physically disabled. The roll of cases receiving rehabilitation services as of June 30, 1938, was about 45,000. The largest number of persons rehabilitated in any single year was 11,091 in the fiscal year 1936-1937.

Foreign Letters

LONDON

(From Our Regular Correspondent)

May 30, 1939.

Dust Diseases of the Lung

In a lecture to the Industrial Welfare Society Dr. Philip Ellman pointed out that in the woolen, cotton, leather and tobacco industries catarrhal infections of the lungs were observed and "cotton bronchitis" had recently received attention in Lancashire, but that there was no evidence of any serious fibrosis of the lungs resulting from exposure to such dusts. On the other hand, the inhalation of certain inorganic dusts might prove very damaging to the lung, producing progressive fibrosis. Inhalation of dust containing silica produced silicosis. In hematite miners, ferric oxide and silica produced a modified form of silicosis, termed siderosis or siderosilicosis. In contrast to the nodular fibrosis of silicosis, asbestos produced diffuse pulmonary fibrosis (asbestosis). Silicate dusts other than asbestos had not been shown to be particularly harmful. In certain cases modified forms of pneumoconiosis resulted from exposure to a mixture of free silica and silicate dusts, and metallic dusts were harmful in proportion to their percentage of free silica. Exposure to ordinary coal dust was not harmful to the lung, but the hazard depended on whether anthracite was present. Apart from anthracosilicosis, so-called miners' asthma, in which free silica dust was present, there was no evidence that ordinary coal dust rendered the miner liable to pulmonary tuberculosis. In trades in which tuberculosis was common and there was some volume of dust apart from silica and asbestos, tuberculosis was probably due to social and economic conditions.

In the discussion which followed, Prof. E. L. Collis stated that he had investigated two conditions due to cotton dust. One occurred in epidemic form among weavers, was almost certainly a mycosis and closely resembled open and early tuberculosis with pyrexia; but in all cases the condition cleared up in a month or so. The other was the chronic asthma of cotton strippers, due to dust from raw cotton. It developed after years of work and was incapacitating but did not predispose to tuberculosis.

Closure of the Ductus Arteriosus

It is usually taught that closure of the ductus arteriosus, which in the fetus carries blood from the pulmonary artery to the aorta, thus by-passing the lungs, is due to the inception of respiration, with expansion of the lungs, causing blood to pass through them from the pulmonary artery. This explanation is now challenged by an x-ray study of the ductus arteriosus in lambs made by A. E. Barclay, Sir Joseph Barcroft, D. H. Barron and K. J. Franklin and recorded in the *British Journal of Radiology*. The fetal lamb was delivered by cesarean section performed on the ewe near term. Colloidal thorium dioxide was injected into a vein, and serial pictures were taken at short intervals by x-ray cinematography over a period of half an hour. The time between delivery and the first exposure was as short as twenty-five seconds in some experiments. The ductus arteriosus was clearly shown in some of the roentgenograms, but a patent vessel was not indicated after about a minute from the time of delivery. After this it appeared as a kinked and beaded structure, and its course and caliber were seen to be continuously changing. It is suggested that these appearances are due to strong localized muscular contractions of the wall of the duct, which produce occlusion. Thus the closure could not be related to the onset of respiration or the arrest of circulation through the umbilical cord, for it took place before any air was seen in the trachea and before the cord was clamped. The origin of the stimulus to closure remains obscure. The only obvious source is alteration in the external environment.

Food Plans for Wartime

Government plans for the control and distribution of food in time of war are announced. A ministry of food would be set up and be the sole importer of all foodstuffs as well as of all home supplies as they left the farm or factory. The wholesaler would buy from the ministry at prescribed prices and the retailer from the wholesaler. It is thought that this would prevent profiteering and speculation and minimize the risks of damage and delay. Immediately on the outbreak of war about 1,400 local food control committees would be set up. Their work would be to register and license retailers and certify their requirements in regard to supplies. Committees of traders have also been set up. Their work would be to make alternative arrangements if local sources of supply should fail owing to an attack or other causes. The government already holds reserves of wheat, sugar and whale oil which can be used to tide over difficulties. For persons evacuated from their homes a forty-eight hour emergency supply would be available in the reception area.

Extensive arrangements have been made for rationing meat, butter, margarine and sugar, but a general rationing of food is thought unlikely. The necessary documents have been prepared, household application forms by which would be obtained cards to enable purchases of prescribed quantities to be made. Nineteen million application forms and sixty million ration cards have been prepared as a temporary scheme. It is expected that an improved scheme will be introduced after six months by which 20,000,000 persons would be entitled to additional rations in consequence of the class of work in which they were engaged.

PARIS

(From Our Regular Correspondent)

May 14, 1939.

Claude Bernard

A new series of publications gives selections from the works of great scientists. Jean Rostand has been entrusted with the task of presenting to the public these selections from the works of the physiologist Claude Bernard, borrowed mostly from his "Introduction to Experimental Medicine" and partly from his lectures at the Collège de France and the Muséum.

Claude Bernard was not only a just and rigorous soul; he was one of the greatest writers of the French language. His style was characterized by Renan as a "true, sober, proportioned style in whatever he has to express," simple language always clear, thought that is vigorous. Such are some of the qualities of Claude Bernard. His literary value was so adequate for his scientific will that he must always remain a great thinker, a great writer and a great scientist. He began by doing menial work in a pharmacy in Lyons and would have never revived physiology if he had not written a tragedy which he took to Paris. Nobody cared for it; he was advised to continue medicine and entered one of the laboratories of the Collège de France, where he was to occupy, later on, the chair of physiology.

It is unnecessary to summarize his discoveries. It is more to the point to consider the struggle he had to carry on against the reigning doctrine of vitalism. The "vital properties" (propriétés vitales) were considered antagonistic to or at any rate different from the natural forces (forces naturelles); living beings were not subjected to the laws governing raw bodies (corps bruts). Claude Bernard proclaimed the contrary and affirmed unity presiding over all phenomena. He demonstrated it by experimentation. Claude Bernard did not explain everything through physics and chemistry. He admitted that science has its limits.

The History of Medicine

The latest meeting of the Société internationale d'histoire de médecine was held in Paris. Medical folklore was the principal object discussed; then the program of the next meeting was adopted, to be held in Berlin in 1940 to consider the evolution of medicine from Harvey to Haller and the history of exanthematous typhus. In addition to studies on medicine and French physicians, the Société française d'histoire de la médecine and its branches have devoted much attention to the ancient Greeks and Arabs, from whom so much knowledge and tradition come. Mr. Souques, for instance, studied at length "Pain in the Writings of Hippocrates." The abundance of hippocratic documentation enabled him to group the observations of the master of Cos according to organs and functions, which makes this study most interesting.

Prevention of Epidemics

One of the most essential tasks confronting the department of organization of hygiene of the League of Nations is to prevent epidemics and their dissemination. Asia, the cradle of civilizations, is the cradle of many diseases as well: for this reason a new office has been set up at Singapore destined to centralize all useful information about epidemics and inform, as quickly as possible, the ports of the Far East about their sudden appearance. A powerful radio station at Malabar, on the Island of Java, broadcasts daily the communications of the main office in Singapore, which is rebroadcast weekly by nine secondary stations. These communications can be received in the ports of the Indian Ocean, of the Pacific and even of the Mediterranean, but for various reasons certain broadcasting stations discontinued their communications and thus several receiving stations remained without information. The Geneva office then decided to centralize these broadcasts; they will be made from Geneva weekly, on wavelengths of 16, 23 and 20, 64 meters, through the station "Radio-Nations" at 8:40 Greenwich mean time and they will be able to reach the remotest receiving sets.

Lister Medal Awarded to René Leriche

The Lister committee awards the Lister medal to a surgeon every three years. The medal displays the portrait of Joseph Lister on one side and a rising sun on the other, as though to symbolize the splendor the great Englishman has cast on his art. A reward of £500 is added to this and the sole obligation connected with receiving it is to give a lecture. Leriche is the sixth beneficiary of the Lister medal, which has been awarded up to the present to only two foreigners, von Eiselsberg and Harvey Cushing. Unquestionably the awarding committee wanted to reward in René Leriche the constant concern to raise surgery, with the aid of the sciences which are at the basis of all the branches of medicine, above a manual function and show that, although specialization is a practical necessity of our profession, it becomes dangerous if it confines the physician to a single branch of medicine.

Professor Leriche received the medal in the main assembly hall of the Royal College of Surgeons in London, where he gave a lecture entitled "The Listerian Conception in 1939."

The Bone Marrow in Recent Syphilis

Benda and Orinstein reported at the Société médicale des hôpitaux de Paris the results of investigations on thirty-five patients, of whom twenty-eight had primary and eight secondary syphilis. In addition there was one case of old syphilis. Sternal puncture was the process used. A drop of liquid bone marrow taken by puncture and mixed with an equal amount of distilled water was examined. The examination was made either after staining with fontana Tribondeau or with the ultramicroscope. On account of rigorous standards in interpretation the results obtained are rather discordant. The authors recognized the incontestable presence of the spirochetes in four cases of primary and one case of secondary syphilis; they report on the other hand six results which they qualify as "partial" and which are just as valid to them as the others. While sternal puncture is simple, it may be difficult to interpret the results. The presence of spirochetes in bone marrow was quite unexpected.

This observation may find therapeutic applications and it is of great doctrinal interest. It joins the already numerous symptoms that indicate the rapid diffusion of syphilis in the organism. Judging by the statistics of Benda and Orinstein, sternal puncture is more conclusive than ganglionic puncture: in twenty cases in which the two tests were applied, the puncture of the ganglion gave four and the puncture of the sternum six positive results.

This session of the Société médicale des hôpitaux de Paris was presided over by Pierre Lereboullet, successor to Georges Guillain in this office.

BERLIN

(From Our Regular Correspondent)

April 24, 1939.

Regulations for the Use of Narcotics

In 1930 there was issued a governmental order regulating the medical prescription of narcotics (THE JOURNAL, Feb. 28, 1931, p. 706; July 1, 1933, p. 61). According to the order, physicians are prohibited from issuing narcotic prescriptions except when they are "medically justified." What was meant by the restrictive words was not explained. However, the basis of the decree of 1930 was the so-called guiding principles set up by the physicians themselves in their convention in Danzig in 1928. These principles have now been expanded and expounded by the national medical leader, Dr. Wagner, in conjunction with the department of public health. The publication of these "Regulations for the Use of Narcotics in Medical Practice" has just taken place. Medical practice will henceforth have to govern itself according to them. The physician should always bear in mind that the first morphine injection may be habit forming. The same is true of every opiate in tablet form. Special precautions are necessary in the case of weak willed or neurasthenic persons, of psychopaths and of those who can easily acquire narcotic drugs, such as physicians, nurses, druggists and their relatives. Wherever feasible the first use should be postponed as long as possible and the narcotic given in small doses. The hypodermic syringe may be intrusted to others only in exceptional cases and that to trustworthy persons acting under medical instructions. The possibility must also be considered that relatives of the patient and other persons may help themselves to the drug. Narcotic prescriptions are to be given only to those who can identify themselves.

Prescription of opiates is medically justified only if after a rigorous examination of the peculiar features of the individual disease the physician arrives at the conclusion that their use is imperative. Recurrent prescriptions are medically justified only if all other possibilities have been exhausted and if the patient is in great pain that will not yield to the usual alleviating remedies. Opiates are indispensable in assuaging exceedingly severe pains, for example in serious accidents and in painful incurable diseases. The use of opiates, the decree continues, generally is not warranted in locomotor ataxia, especially the initial stages; in bronchial asthma, only in exceptional cases; in bronchitis, almost never. Narcotics and soporifics are two different things. In heart disease, generally speaking, only individual doses of opiates are necessary; for example, in angina pectoris and cardiac asthma, after other measures have proved unsuccessful. Psychoses make the use of opiates unavoidable only in serious cases. The prescription of opiates may be necessary after careful diagnosis in grave

cases of renal and biliary calculus. The danger that the physician may be imposed on is particularly great; to furnish recurrent prescriptions simply means supporting a habit induced by previous prescriptions. Complaints of pain in amputated stumps, the extent of which is often difficult to estimate, demand a careful examination of the whole personality of the patient and his trustworthiness, especially when prescription of opiates is a standing order.

The regular prescription of opiates for addicts, in the absence of evidence that the original disease persists, is medically justifiable only if withdrawal would endanger the patient's life. Social reasons, e. g. the assertion that the patient cannot afford to interrupt his work to undergo treatment, do not justify continuance of the drug. The physician's underlying purpose in the treatment of addicts must be to plan a scientifically sound and progressive withdrawal and to supplement it with psychiatric measures. The minimal quantity of morphine indispensable in preventing serious conditions secondary to abstinence must be ascertained individually in the addict himself but independently of his statements. It is always considerably less than the quantity actually last taken by him: about one half or one third of what he alleges. The use of cocaine has already been restricted to the practice of specialists. Even here it can be replaced by one of the more recent local anesthetics which are not habit forming.

Epidemic Keratoconjunctivitis

About the middle of July 1938 there appeared in Berlin an ocular disease affecting the conjunctivae and the uppermost layers of the cornea. It was diagnosed by the university clinic as keratoconjunctivitis epidemica. The presence of the same disease was also reported from Bonn and Munich. Other parts of Germany seemed to have been unaffected. About 150 patients were clinically observed after the middle of the year. Primary indication was that resembling general influenza, followed by edematous catarrhal conjunctivitis. The bulbar conjunctiva in many cases showed vesiculation. Occasionally, small petechial hemorrhages were found. Secretion was almost never suppurative. Though the cornea and iris were not involved, patients complained of photophobia and the presence of a foreign body. Frequently there occurred a swelling of the regional lymphatic glands. After from eight to twelve days the severity of the inflammation relaxed. At this time, usually, opacity of the cornea set in, affecting mostly the center of the cornea but in evidence also in the regional portions. Dr. Smitmans connected with the clinic reported the visibility, even under weak magnification, of globular and oval, indistinctly defined, centers, which often were somewhat prominent, preponderantly intra-epithelial, without, however, penetrating to an extensive degree. In individual cases the centers appeared circular and linear and a certain connection seemed to exist between them and the epidermal nerves. The centers would then remain for a long time completely unchanged. Neither vascular proliferation of the cornea nor a severe irritation of the iris was observed. The conjunctivae were usually affected on both sides. Corneal infection was almost always noticeable, even though only a slight one. Visual acuity was generally considerably reduced at the height of the disease and in individual cases as much as 5/35 but improved after the subsidence of the acute inflammation. A slighter deterioration in visual power from 5/7 to 6/10, depending on the condition of the cornea, persisted. Generally patients of middle and advanced age were affected, sometimes also children. This outbreak was extremely infectious, spreading not only to members of the family but also to ophthalmologists, probably by exogenic transmission. Penetration to the deeper parts of the eye did not seem to occur. The incubation period apparently extended from five to seven days. Attempts to transfer conjunctival secretions to rabbits as well as intracorneal and intracerebral injections gave negative results. Treatment consisted of daily application of a 1 per cent solution of silver nitrate. This seemed to heal conjunctivitis more rapidly and to reduce corneal infection. The iris was treated with atropine; the cornea, however, could not be cleared up.

A Berlin ophthalmologist who had observed about 700 patients within this period found corneal complications in about half of them. He found opacities under Bowman's membrane and exceedingly numerous ones in the pupillary region. These hindered vision exceedingly, were exceptionably stubborn and did not begin to clear up until six or eight days after. Toward the end a more severe corneal infection in herpes form made its appearance and extended in some cases to the edges of the cornea. Singularly enough, corneal infections never appeared at the beginning of the disease but only after the acute stage had passed and the worst was believed to be over. The appearance of the disease in different sections of the business center of Berlin with its many offices and vitiated air was to be expected, in view of the many cases of chronic conjunctivitis generally found there. The infection often remained unilateral, even in serious cases.

Results of Shock Therapy in Schizophrenia

In 1933 Sakel introduced insulin and in 1934 Meduna introduced metrazol in the treatment of schizophrenia. A numerical evaluation based on a questionnaire sent by the governmental department of public health to the psychiatry clinics of the German universities yields the following figures:

Therapy	No. of Patients Treated	No. of Reporting Clinics	Symptom Free	Improved	Not Improved
Insulin	560	10	211 (37.7 per cent)	162 (28.9 per cent)	187 (33.4 per cent)
Metrazol	132	7	25 (18.9 per cent)	49 (37.1 per cent)	58 (44 per cent)
Metrazol and insulin	67	5	27 (40.3 per cent)	18 (26.9 per cent)	22 (32.8 per cent)

The official conclusions are that both of these therapies are of extraordinary value. About sixty-seven patients, equal to 56 per cent of the total number, could be regarded as favorably influenced.

The department of labor, charged with the management of the sick fund, has now ordered that metrazol therapy may be given to schizophrenic patients at the expense of the sick fund. Official permission to employ insulin therapy was granted in May 1938.

Studies on Poliomyelitis

Like other studies on the epidemic of poliomyelitis of 1937 and 1938, the pathologic studies of 1938 have now been made public. Dr. Heinlein was able to examine thirty-eight of the forty-eight cases involved. The age of the patients ranged from 6 months to 56 years. The inner organs, including the endocrine glands, showed no specific changes. The occasionally observed inflammations of the throat and tonsils were probably not sequelae but either subsequent to it or perhaps precursors of it. There were edema in the gray and white matter, hyperemia and in many cases microscopic hemorrhages, which perhaps are to be regarded as directly toxic impairments of the wall of the vessels. Frequently Clarke's columns were diseased; the lateral horns less so. The white matter, likewise, showed specific changes; only the dorsal portions of the medulla oblongata and pons were diseased. The base of the pons was always free from disease. In the cerebellum regularly changes were found, especially in the region of the dentate nucleus. These might explain appearances of ataxia, unless

the injury of Clarke's column was responsible for them. In two patients clinically spastic phenomena were most prominent, with negligible anatomic changes in the myelon but serious ones in the medulla oblongata, pons and telencephalon. In a few cases a predominantly cerebral form of poliomyelitis seems to have existed.

POLAND

(From Our Regular Correspondent)

Warsaw, May 1, 1939.

Action of Mercurial Diuretics

Dr. J. Fliederbaum has reported his research performed at the university clinic of Warsaw on the action of mercurial diuretics. Among fifty patients there were thirty with cardiac edema and nine with edema of extracardiac origin. He studied the effect of mercurial diuretics on the protein and carbohydrate metabolism and acid-base equilibrium of the blood, and the influence on excretion of water, salt, phosphates and nitrogen by the kidneys. Simultaneously the influence on the blood volume and on the functions of the reticulo-endothelial system was examined. On the basis of these examinations the author divided the action of the mercurial diuretics into three periods.

In the first period the water balance is not yet influenced by the drug and no diuretic action is observed. There appear however important changes in the distribution of blood and of tissue fluid and in the chemical composition of the blood. The absorption of saline solution injected into the skin diminishes. The return of the tissue fluid into the blood vessels increases, causing a marked rise in the circulating blood volume. In this period there is also observed an increase in the acid secretion by the stomach, in lung ventilation, in carbon dioxide excretion and in oxygen consumption; also the respiratory quotient and the level of the blood sugar undergo noticeable changes. Injected dye is to a less extent absorbed by the reticulo-endothelial system.

The second period begins with the onset of diuresis. This period the author divides into two parts. In the first the kidney threshold for water and salt excretion drops, and these substances are excreted in great amounts by urine, while the threshold for excretion of other substances, especially phosphates and nonproteinic nitrogen, increases in spite of the rise in their blood level.

In the second part of the second period the mercurial diuretics provoke a destruction of the tissue proteins. The level of nonprotein nitrogen in blood increases sometimes very much. This is accompanied by an increased excretion of water by extrarenal ways, chiefly by the lungs and the skin. Such increase in extrarenal water secretion occurs also in other conditions in which there is a toxic destruction of tissues, e. g. animals after experimental extirpation of the adrenal glands. In the toxic period of action of the mercurial diuretics many patients, especially those who for a long time have received the drug, complain of uremia-like symptoms due to intoxication with the products of destruction of tissue proteins: weakness, headache, nausea and psychic depression.

In the third period all the foregoing changes recede. However, the sensitiveness of the organism to repeated administration of diuretics remains diminished.

In patients with chronic circulatory failure the mercurial diuretics produce a deacidifying influence on the organism: there is increase in the stomach acid secretion, the carbon dioxide excretion by the lungs, the urinary acidity and the basic reserves of the plasm.

Genesis of Reticulocytes

Drs. F. Goebel and S. Marczewski reported before the Warsaw Medical Society their results of research on the genesis of reticulocytes performed in the Institute of Experimental Pathology of Warsaw University. They noticed that the erythrocyte and reticulocyte counts increase in dogs which are exposed to a low atmospheric pressure for a short time (sixty seconds). This phenomenon does not occur in splenectomized dogs. Other factors which induce a contraction of the spleen, such as intravenous injection of epinephrine or bleeding, also cause a prompt increase in the reticulocyte count of the blood. This rise after the administration of the same agents does not occur in splenectomized dogs. From these facts it can be assumed that reticulocytes as well as old erythrocytes are retained in the spleen. Thus the authors say that the reticulocytes are not young red cells, as has been commonly thought. This view is also confirmed by some clinical observations. So the reticulocytosis encountered in hemolytic jaundice can be regarded as a result not of blood regeneration but of increased erythrocyte destruction in the spleen. The reticulocytosis observed after blood transfusions can also be caused by an increased destruction of the introduced foreign red cells.

Bactericidal Action of Saliva

In the State Institute of Hygiene at Warsaw, research was performed by Dr. A. Lande concerning the germicidal action of human saliva. The results to some extent confirm the formerly known fact that saliva contains a bactericidal body, called inhibin, which hampers the growth of micro-organisms. This factor cannot be passed through the Chamberland filter. It is nonspecific, for it is active against many species of microbes. Nor is it identical with the lysozyme found in saliva by Flemming, for it does not resist heating to 56 C.

The author performed further research on the immunologic importance of inhibin. He examined the saliva of 152 subjects, among whom were 100 children from an orphanage, all of whom since their birth have lived together and have been about equally exposed to infections. There was a close relation between the morbidity from infectious diseases due to micro-organisms in the mouth and pharynx, and the frequency of the presence of inhibins in saliva. Inhibin was present in only 5.33 per cent of the subjects who gave a history of repeated anginas, diphtheria or scarlet fever or had chronic tonsillitis, while in subjects who had never been ill with these diseases the percentage of having inhibin in saliva was 38.46.

The epidemiologic importance of inhibins is more obvious as far as the morbidity with diphtheria alone is concerned. They were found neither in diphtheria carriers nor in any subject who had ever had diphtheria. It was also found that the presence or absence of inhibin in saliva is independent of serologic immunity.

The author says that the bactericidal factors of saliva are the first barrier set against infection. Besides inhibin the human saliva contains also other germicidal bodies, such as yeast.

Marriages

JOHN HAMPTON MILLER, Thomas, W. Va., to Miss Frances Taylor of Bridgewater, Mass., March 19.

RANDALL G. SPRAGUE, Rochester, Minn., to Miss Anne Whitcomb of Grand Forks, N. D., April 8.

GEORGE WILLIAM LAWSON, Star, N. C., to Miss Edna Ann Thomas of Jonesboro, April 29.

HOWARD LEE SMITH to Miss Jean Harriett Goss, both of Washington, D. C., March 4.

DONALD R. BRUMLEY, Macomb, Ohio, to Miss Helen Huntley of Davenport, Iowa, May 13.

WILLIAM GARBE to Miss Lorna Levey, both of Toronto, Ont., Canada, May 7.

WARREN W. YOUNG to Miss Dorothy Johnson, both of Chicago, May 6.

JOSE M. FERRER JR., to Miss Mary Schumacher, both of New York, June 6.

Deaths

Lee Harrison Mettler, Hubbard Woods, Ill.; Jefferson Medical College of Philadelphia, 1886; professor of neurology, emeritus, at the University of Illinois College of Medicine, Chicago; prosector and assistant to the chair of anatomy, 1886-1887, chief of the medical clinic, 1887-1891, lecturer and clinical instructor of mental and nervous diseases and electrotherapeutics, 1888-1891, Medico-Chirurgical College of Philadelphia; formerly secretary of the Chicago Neurological Society; attending neurologist to the Cook County Hospital, Chicago, 1904-1906, and Norwegian Lutheran Deaconess Home and Hospital, Chicago; author of "Treatise on Diseases of the Nervous System," published in 1905; aged 75; died, March 20, in the Highland Park (Ill.) Hospital.

Menzies John MacFarlane ⊕ Cedar City, Utah; Jefferson Medical College of Philadelphia, 1913; past president of the Utah State Medical Association; past president of the county board of education and member of the state board of education; on the courtesy staff of the Iron County Hospital; aged 57; died, March 24, at the Dr. W. H. Groves Latter-Day Saints Hospital, Salt Lake City, of a streptococcic infection of the throat with complications.

Levin H. A. Nickerson, Quincy, Ill.; University of Pennsylvania Department of Medicine, Philadelphia, 1874; member and past president of the Illinois State Medical Society; past president and secretary of the Adams County Medical Society; member of the House of Delegates of the American Medical Association, 1908-1909; aged 88; died, March 13, in St. Mary's Hospital.

Victor H. Marchand ⊕ Haubstadt, Ind.; University of Louisville (Ky.) Medical Department, 1883; Jefferson Medical College of Philadelphia, 1884; past president of the Gibson County Medical Society; bank president; aged 76; died, March 19, in the Welborn-Walker Hospital, Evansville, of injuries received in an automobile accident.

Edward Vincent Murphy ⊕ Newport, R. I.; College of Physicians and Surgeons, Baltimore, 1899; township health officer; past president of the Newport County Medical Society; formerly connected with the United States Public Health Service; on the staff of the Newport Hospital; aged 68; died, March 9, of cerebral hemorrhage.

Charles Higgins Cole, Binghamton, N. Y.; Albany (N. Y.) Medical College, 1894; member of the Medical Society of the State of New York; for many years superintendent of the Tuberculosis Hospital of the County of Broome, Chenango Bridge; aged 68; died, March 24, of diabetes mellitus and mesenteric thrombosis.

Leo Alexander Newcomb, Montpelier, Vt.; University of Vermont College of Medicine, Burlington, 1901; member of the Vermont State Medical Society; past president of the Washington County Medical Society; served during the World War; aged 62; on the staff of the Heaton Hospital, where he died, March 3.

Charles Alexander Martin, Amherstdale, W. Va.; University of Louisville (Ky.) Medical Department, 1908; member of the West Virginia State Medical Association; past president of the Logan County Medical Society; aged 59; died, March 25, of hypertensive heart disease with myocardial insufficiency.

W. H. Post, Masontown, W. Va.; Baltimore Medical College, 1901; member of the West Virginia State Medical Association; at one time superintendent of the Hopemont (W. Va.) Sanitarium; formerly member of the school board; aged 61; died, March 18, in the Monongalia County Hospital, Morgantown.

Harold Oliver Lund, Middletown, Ohio; University of Minnesota Medical School, Minneapolis, 1922; member of the Ohio State Medical Association and the American Academy of Pediatrics; served during the World War; on the staff of the Middletown Hospital; aged 41; died, March 6, of heart disease.

John Franklin Dunseith, New York; College of Physicians and Surgeons, Medical Department of Columbia College, New York, 1895; member of the Medical Society of the State of New York; formerly member of the health department; aged 63; died, March 6, at New Rochelle of angina pectoris.

Wilbur Thomas Myers, Uniontown, Pa.; University of Louisville (Ky.) Medical Department, 1909; member of the Medical Society of the State of Pennsylvania; also a pharmacist; aged 55; died, March 2, of diabetes mellitus, rupture of the femoral artery and colon and septicemia.

John Isaac Becker, Poughkeepsie, N. Y.; Syracuse University College of Medicine, 1905; member of the Medical Society of the State of New York; aged 68; died, March 13, in the Vassar Brothers Hospital of carcinoma of the mediastinum and obstruction of the esophagus.

John Howard McCulloch ⊕ Beckley, W. Va.; University College of Medicine, Richmond, 1908; medical superintendent of the Beckley Hospital; fellow of the American College of Surgeons; aged 53; died, March 18, of a skull fracture received in a fall down the stairs.

Jasper Victor Howard ⊕ Medical Inspector, Commander, U. S. Navy, San Francisco; University of Pennsylvania School of Medicine, Philadelphia, 1909; fellow of the American College of Surgeons; entered the navy in 1910; aged 56; died, March 12, of heart disease.

Gerald James A. Dolan, Brooklyn; Georgetown University School of Medicine, Washington, D. C., 1938; aged 26; intern at St. Mary's Hospital, where he died, March 2, of embryogenic carcinoma of the right testicle with metastasis to the abdomen, lung and brain.

Hugh Herald Miltimore ⊕ St. Johnsbury, Vt.; University of Vermont College of Medicine, Burlington, 1907; past president and secretary of the Caledonia County Medical Society; on the staff of the Brightlook Hospital; aged 55; died, March 1, of angina pectoris.

Charles H. W. Auel, Buffalo; University of Buffalo School of Medicine, 1886; member of the Medical Society of the State of New York; for many years on the staff of the Memorial Hospital; aged 75; died, March 16, of chronic myocarditis and cerebral hemorrhage.

James Carl Minor, Long Beach, Calif.; University Medical College of Kansas City, Mo., 1891; member of the Missouri State Medical Association; fellow of the American College of Surgeons; aged 69; died, March 24, of heart disease.

Lewis De Witt Hews, Rockwell City, Iowa; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1901; aged 62; died, March 25, in Des Moines of carcinoma of the sigmoid colon and peritonitis.

Robert Eugene Miller, Lansing, Mich.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1890; member of the Michigan State Medical Society; aged 70; died, March 1, of cardiovascular renal disease.

Francis Cicero McDowell ⊕ Siler City, N. C.; University of Pennsylvania Department of Medicine, Philadelphia, 1902; aged 65; died, March 14, in the Piedmont Memorial Hospital, Greensboro, of influenza and pneumonia.

Alvah Smith McClain, Kansas City, Mo.; Cleveland College of Physicians and Surgeons, Medical Department Ohio Wesleyan University, 1898; served during the World War; aged 72; died, March 10, of coronary thrombosis.

Laurence Joseph Murphy, Evanston, Ill.; University of Illinois College of Medicine, Chicago, 1931; member of the Illinois State Medical Society; aged 31; died, March 17, in St. Petersburg, Fla., of chronic nephritis.

William Preiss, Buffalo; Niagara University Medical Department, Buffalo, 1895; member of the Medical Society of the State of New York; aged 68; died, March 3, of coronary thrombosis and arteriosclerosis.

Harold Lewis Bollig ⊕ Los Angeles; University of Nebraska College of Medicine, Omaha, 1929; on the staff of the Methodist Hospital of Southern California; aged 36; died, March 21, of lobar pneumonia.

Charles De Forest Lucas, Charlotte, N. C.; University of Virginia Department of Medicine, Charlottesville, 1926; member of the American Radium Society; aged 40; died, March 13, of lymphosarcoma.

Earl Victor Bobb, Alhambra, Calif.; Northwestern University Medical School, Chicago, 1899; member of the American Academy of Ophthalmology and Oto-Laryngology; aged 64; died, March 4.

Henry West Hughes, Los Angeles; College of Physicians and Surgeons, Medical Department of Columbia College, New York, 1885; aged 80; died, March 15, in the Hospital of the Good Samaritan.

John Dane, Boston; Harvard University Medical School, Boston, 1892; member of the Massachusetts Medical Society; formerly instructor in orthopedics at his alma mater; aged 72; died, March 27.

John Wesley Mullin, Wilmington, Del.; Hahnemann Medical College and Hospital of Philadelphia, 1886; on the staff of the Homeopathic Hospital; aged 73; died, March 2, of pneumonia.

William E. Miller ⊕ Chicago; College of Physicians and Surgeons of Chicago, 1887; on the staff of the Hospital of St. Anthony de Padua; aged 81; died, March 25, of uremia and nephritis.

Luther Francis Kepler, Cedar Rapids, Iowa; Keokuk (Iowa) Medical College, College of Physicians and Surgeons, 1904; aged 58; died, March 1, of uremia, nephritis and hypertension.

Jasper Eugene Neighbors ⊕ Hobbs, N. M.; University of Arkansas School of Medicine, Little Rock, 1918; formerly on the staff of the Hobbs General Hospital; aged 52; died, March 22.

Frederick Randolph Abbe ⊕ Boston; Harvard University Medical School, Boston, 1895; medical director of the Loyal Protective Life Insurance Company; aged 70; died, March 2.

Archie Schuyler Brown, Indianapolis; Medical College of Indiana, Indianapolis, 1904; served during the World War; on the staff of the Methodist Hospital; aged 62; died, March 12.

Thomas P. McCullough, Detroit; Queen's University Faculty of Medicine, Kingston, Ont., Canada, 1888; aged 78; died, March 2, of chronic endocarditis and bronchial asthma.

Norman Henry McCrummin, Montgomery, Ala.; Vanderbilt University School of Medicine, Nashville, Tenn., 1884; aged 85; died, March 26, of hypostatic pneumonia.

Harry Mandel ⊕ Chicago; General Medical College, Chicago, 1923; aged 41; on the staff of the Englewood Hospital, where he died, March 15, of coronary thrombosis.

Charles Lafleur, Montreal, Que., Canada; Laval University Medical Faculty, Montreal, 1908; for many years physician for the fire department of Montreal; died, March 31.

James Johnston Fraser, Hamilton, Ont., Canada; University of Toronto Faculty of Medicine, 1902; on the staff of the Ontario Hospital; aged 62; died, March 30.

Everett Rexford Myles, Windsor, Ont., Canada; University of Toronto Faculty of Medicine, Toronto, 1924; aged 49; died, February 26, in the Grace Hospital.

George Lewis Megargee, Larchmont, N. Y.; University of Pennsylvania Department of Medicine, Philadelphia, 1901; aged 65; died, March 4, in Altamonte, Fla.

Harriet S. MacBeth, Fort Wayne, Ind.; Fort Wayne College of Medicine, 1893; aged 66; died, March 18, of diabetes mellitus, arteriosclerosis and heart disease.

Luther Edwards, Finley, Tenn.; Memphis Hospital Medical College, 1906; member of the Tennessee State Medical Association; aged 59; died, March 31.

Howard P. Johnson, Cortland, N. Y.; Hahnemann Medical College of Philadelphia, 1881; aged 83; died, March 4, of arteriosclerosis and cerebral edema.

Elizabeth Rabb Beatty, Lansdowne, Ont., Canada; Queen's University Faculty of Medicine, Kingston, 1884; formerly a medical missionary; died in March.

James Alvin Cannon, Pickens, S. C.; Southern Medical College, Atlanta, Ga., 1881; county physician; aged 85; died, March 24, of cerebral hemorrhage.

George Ernest Myers, Cheshire, Conn.; University of Vermont College of Medicine, Burlington, 1896; aged 71; died, March 25, of coronary thrombosis.

William Albert Harvey, Berryville, Ark.; St. Louis University School of Medicine, 1909; aged 55; died, March 15, of arteriosclerosis and myocarditis.

Walter N. Boyer, Culver City, Calif.; Hahnemann Medical College and Hospital, Chicago, 1881; aged 80; died, March 2, in a hospital at Los Angeles.

Samuel John MacLennan, Windsor, N. S., Canada; Bellevue Hospital Medical College, New York, 1894; served during the World War; died recently.

Fanny Searls Gradle, Santa Barbara, Calif.; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1877; aged 87; died, May 24.

William Stanley Hill, Pelham, Ga.; Atlanta Medical College, 1892; aged 72; died, March 7, of cerebral hemorrhage, nephritis and arteriosclerosis.

Carlos M. Garza, Lampazos, Nuevo Leon, Mexico; Universidad Nacional Facultad de Medicina, Mexico, D. F., 1888; aged 79; died, March 5.

Robert De Vean Gilman, Beverly Hills, Calif.; New York Homeopathic Medical College and Hospital, New York, 1915; aged 45; died, March 20.

John L. Stephenson, Santa Ana, Calif.; University of Minnesota College of Medicine and Surgery, Minneapolis, 1895; aged 81; died, March 20.

James Clarke McClester, Harrisville, Ohio; Ohio Medical University, Columbus, 1894; served during the World War; aged 70; died, March 23.

Christopher W. Stoll, Dover Center, Ohio; Western Reserve University Medical Department, Cleveland, 1893; aged 70; died, February 17.

Joseph Graeme Foster, Ottawa, Ont., Canada; McGill University Faculty of Medicine, Montreal, Que., 1923; aged 40; died, February 22.

Frank R. Farrell, Milwaukee; Milwaukee Medical College, 1905; aged 68; died, March 16, in St. Anthony's Hospital of angina pectoris.

Holly W. Casto, Ravenswood, W. Va.; Starling Medical College, Columbus, 1896; aged 66; died, March 22, of cardiorenal insufficiency.

Willis Benton Cauble, Murphysboro, Ill.; Rush Medical College, Chicago, 1888; aged 72; died, March 10, in San Francisco of uremia.

Joseph E. Beck, Carmel, Calif.; State University of Iowa College of Homeopathic Medicine, Iowa City, 1887; aged 76; died, March 2.

Charles T. Gustin, Denver; Detroit College of Medicine, 1897; also a pharmacist; aged 67; died, March 23, of myocarditis and influenza.

John Proudfoot, Monkton, Ont., Canada; Western University Faculty of Medicine, London, 1888; aged 75; died, February 28.

York Patchen, Westfield, N. Y.; Western Reserve University Medical Department, Cleveland, 1886; aged 77; died, February 21.

Harry L. Vradenburg, Plattsmouth, Neb.; Hahnemann Medical College and Hospital, Chicago, 1886; aged 85; died, February 19.

Wardlaw Ewell, Crawfordsville, Ind.; Kentucky School of Medicine, Louisville, 1891; aged 72; died, March 12, of cerebral hemorrhage.

John Patrick Matthews, Leesburg, Ala.; University of Tennessee Medical Department, Nashville, 1879; aged 85; died, March 10.

Tillman Brooks Bradford, Toone, Tenn.; Vanderbilt University School of Medicine, Nashville, 1892; aged 73; died, March 15.

Henry Herbert Baker, Cairo, Ill.; University of Louisville (Ky.) Medical Department, 1907; aged 58; died, March 22, of influenza.

Hector Roy, Montreal, Que., Canada; Victoria University Medical Department, Coburg, Ont., 1890; aged 75; died, February 21.

John Breckinridge Woodville, Lansing, W. Va.; Medical College of Virginia, Richmond, 1897; aged 69; died, February 14.

Russell James Smith, Toronto, Ont., Canada; University of Toronto Faculty of Medicine, 1892; aged 69; died, February 12.

Brenton Johnson Hazlewood, Oshawa, Ont., Canada; Trinity Medical College, Toronto, 1899; aged 64; died, February 17.

John C. Cunningham, Hixson, Tenn.; Chattanooga Medical College, 1898; aged 71; died, March 28, of cerebral hemorrhage.

Ira Albert Freel, Stouffville, Ont., Canada; University of Toronto Faculty of Medicine, 1882; aged 78; died, February 20.

Alvah D. Decker, Staten Island, N. Y.; Long Island College Hospital, Brooklyn, 1876; aged 90; died, February 15.

Thomas Arthur Ellis, Toronto, Ont., Canada; University of Toronto Faculty of Medicine, 1920; aged 59; died, March 21.

James Piner Bartley, Duncan, Okla.; Kentucky School of Medicine, Louisville, 1898; aged 72; died in February.

Charles W. Tufts, Wyoming, Ohio; Medical College of Ohio, Cincinnati, 1884; aged 83; died, February 15.

Morris Barrett, Maidens, Va. (licensed in Virginia in 1885); aged 76; died, March 10.

Levi S. Correll, Jacksonville, Fla. (licensed in Illinois in 1878); aged 93; died, March 3.

Bureau of Investigation

THE VITA COMPANY FRAUD

A Chicago Mail-Order Quackery Debarred from the Mails

A small but dangerous medical mail-order fraud was debarred from the mails on Sept. 2, 1938. It was conducted from Chicago and, according to a memorandum of the Acting Solicitor for the Post Office Department to the Postmaster General, was carried on by one Chester A. Cremin and his wife. These persons advertised and sold through the mails a preparation called "Vita Vaginal Suppositories," which they claimed were a treatment for suppressed or excessive menstruation, "whites," vaginitis, inflammation and tumors of the uterus, as well as for displacements and prolapse of that organ.

The business was said to have been started about forty-three years ago by Mr. Cremin's mother. While Cremin was said to have declared that he was the sole owner of the business, the federal authorities charged that Cremin's wife actually conducted the business. The files of the Bureau of Investigation of the American Medical Association contain an advertising leaflet issued in 1929 and entitled "Vita Means Life for Ladies."

It was put out by The Vita Company (Not Inc.) at 8237 Maryland Avenue and 1039 East Eightieth Street, Chicago, "Mrs. C. A. Cremin, Mgr." At that time the Vita Company listed some sixteen diffent preparations, of which Vita Vaginal Suppositories seemed to be the major opus, although there was also a "Vita Catarrah [sic] Ointment" on the list.

The Cremins are said to have told the Post Office inspectors that the vaginal suppositories contained lanolin, vaseline, cocoa butter, ichthyol, alum and borax. The government chemists found that they actually consisted of boric acid, Glauber's salt, petrolatum and lycopodium. As neither combination could by any stretch of the imagination cure the conditions set forth in the advertising, and moreover, as sole reliance on this "patent medicine" might in certain cases lead to serious illness or even death, the scheme was declared a fraud and on Sept. 7, 1938, the mails were closed to the Vita Company and to Mrs. C. A. Cremin, Mgr.

AN OBESITY CURE FRAUD

The Gessner-Laun Swindle Barred from the Mails

The United States mails have been closed to a mail-order fake known as "Dr. Laun Sales Co.," doing business from 207 North Michigan Avenue, Chicago. The information that follows is based on a memorandum by the Hon. W. E. Kelly, Acting Solicitor for the Post Office Department, to the Postmaster General, and also on material in the files of the Bureau of Investigation of the American Medical Association.

The business was conducted by one Joseph E. Gessner, who sold through the mails a preparation called "Dr. Laun's Stimulating and Reducing Balm." This preparation, according to Gessner, would, when rubbed on the body by obese persons, make fat "melt away like magic." The name of Gessner appears previously in the files of the Bureau of Investigation of the American Medical Association. In July 1937 J. E. Gessner of 207 North Michigan Avenue, Chicago, was reported

•NEVER A HUNGRY MOMENT•
HOW AMAZING NEW EXTERNAL REDUCER
MAKES YOU LOSE FAT!
SAFELY · EASILY · QUICKLY Or No Cost
NO LIQUID, PILLS, OR LAXATIVES TO TAKE. NO DIETING • NO EXERCISING • LOSE POUNDS & INCHES
If you're too fat, not due to gland trouble—if dieting is a hardship and you fear drugs—just eat 3 square meals daily and rub on delightful Dr. Laun's Stimulating and Reducing BALM. Pay nothing if reducible pounds and inches of excess fat doesn't melt away almost like magic from neck, double chin, arms, bust, abdomen, hips, calves, ankles and feet. You are the judge. If the first 10 days treatment doesn't show the way to lose bulky weight, regain slender, fashionable youthful curves, gain in health and vigor, without one minute's discomfort, return the empty treatment for full refund. Reducing is up to you!
ARMS
BUST
HIPS
CALVES
ANKLES
SEND NO MONEY—TEST AT OUR RISK
Write today for the 10-day treatment of Dr. Laun's Reducing and Stimulating BALM. Deposit $1.00 plus postage with postman when it arrives. Money refund GUARANTEED on return of empty treatment if you're not delighted with results in 10 days. Send remittance with order and we pay postage. Don't delay. Test this new easy way to reduce at our risk.
Dr. Laun Sales Co., Dep. 3-SC, 207 N. Michigan, Chicago, Ill.

by the Federal Trade Commission to have agreed "to discontinue false and misleading advertising" in connection with the sale of an alleged treatment for piles.

When the government chemists analyzed Dr. Laun's Reducing and Stimulating Balm they found the nostrum to consist essentially of alcohol, water, camphor, tragacanth and epsom salt. Of course, rubbing such a mixture on the skin of a stylish stout would not reduce her weight—especially if she followed Gessner's suggestion that she "eat 3 square meals daily."

On Sept. 1, 1938, a fraud order was issued, closing the mails to Dr. Laun Sales Co. and its officers and agents as such.

On June 15, 1939, the Federal Trade Commission released stipulation No. 2480:

Joseph E. Gessner, trading as Dr. Laun Sales Company, 207 North Michigan Ave., Chicago, agrees to cease disseminating advertisements representing that "Dr. Laun's Reducing and Stimulating Balm," either with or without the application of massage, will remove fat from the body or any part thereof or that the preparation or any of its ingredients has any value as a reducing agent.

MISBRANDED "PATENT MEDICINES"

Abstracts of Notices of Judgment Issued by the Food and Drug Administration of the United States Department of Agriculture

[EDITORIAL NOTE.—The abstracts that follow are given in the briefest possible form: (1) the name of the product; (2) the name of the manufacturer, shipper or consigner; (3) the composition; (4) the type of nostrum; (5) the reason for the charge of misbranding, and (6) the date of issuance of the Notice of Judgment—which is considerably later than the date of the seizure of the product and somewhat later than the conclusion of the case by the Food and Drug Administration.]

Glandeen Tablets.—Lucky Heart Laboratories, Inc., Memphis. Composition: Extracts of plant drugs including damiana and nux vomica, with iron carbonate, coated with chalk and sugar. Fraudulently represented as a "powerful strength invigorator," to restore lost vitality or "lost manhood," etc.—[*N. J. 28311; September 1938.*]

Preacher's No-Ru Kidney Bladder Rheumatism Backache Remedy.—Lucky Heart Laboratories, Inc., Memphis. Composition: Essentially small amounts of potassium acetate, methenamine and extracts of plant drugs, with sugar and water. Fraudulent therapeutic claims.—[*N. J. 28311; September 1938.*]

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

POSTOPERATIVE PULMONARY COLLAPSE

To the Editor:—What is the best method of treating the following postoperative complication in the chest: A day or two after operation the chest fills up with bubbling rales, which may be audible at the foot of the bed. The respirations are accelerated and there is some peripheral cyanosis. The temperature is elevated (from 101 to 102 F.). A rasping wheeze is audible and a cough, which may be productive of a thick, tenacious, greenish yellow sputum, is present. Examination of the chest reveals only large bubbling rales (the appearance is similar to that seen in pulmonary edema). There is no evidence of consolidation. This complication has frequently occurred in my cases postoperatively. The last one was in a man aged 74 who had had a suprapubic cystotomy done under local anesthesia. He showed no evidence of any latent or evident cardiac condition or respiratory disorder prior to operation.

M.D., New York.

ANSWER.—The condition described suggests postoperative pulmonary collapse followed by temporary failure of the circulation, or perhaps the latter condition alone. The large bubbling rales may be caused by secretions in the larger bronchi or may indicate the presence of pulmonary edema.

If atelectasis is the cause, prevention is more important than treatment. After operation the patient should not be deeply narcotized; cough, unless excessive, should not be too greatly suppressed, and tight binders should not be placed about the chest or abdomen. The patient's position in bed should be changed frequently. Collections of secretion in the pharynx or larynx should be aspirated with a suction apparatus. It is important to keep the patient warm and well but not excessively supplied with fluids.

If atelectasis has already occurred, the patient should be rolled from side to side occasionally or should lie with the affected side up to facilitate drainage of secretion. Bronchoscopy and aspiration may be tried. A mixture of oxygen and 5 per cent carbon dioxide should be given by inhalation if the patient will not or cannot voluntarily breathe deeply. Oxygen therapy by nasal catheter or tent may relieve the tachypnea and cyanosis. If pulmonary edema is present, fluids should be restricted. Digitalis and so-called cardiac stimulants such as camphor or strychnine have no place in the treatment of this condition. Hypodermic injection of atropine sulfate 1.3 mg. (1/50 grain) and solution of epinephrine hydrochloride U. S. P. 0.5 cc. (8 minims) may aid in clearing the lungs of bubbling rales but may increase the tachycardia.

ASTHMA IN SMALL BOY

To the Editor:—A boy aged 3 years 4 months, has severe asthma. He is sensitive to a few foods as shown by skin tests, but avoidance of these foods does not eliminate the wheezing. He is not sensitive to any of the epidermals or pollens. However, his asthma is worse at night and when the wind is from the west. I would appreciate any help you could give me on further diagnosis or treatment.

M.D., Illinois.

ANSWER.—The information given is insufficient for making even a tentative conjecture regarding the diagnosis. In general it may be said that infection seldom plays an important part as a primary cause of asthma in this age group. The important causes are the inhalants and the foods. A careful history is of utmost importance in the diagnosis. Such a history is more valuable if it is based on the attempt of interpretation of the various attacks over a period of months or longer.

Among the important factors to be studied are the seasonal or perennial nature of the complaint or exacerbations during any particular period of the year, the environmental contacts, as the furnishings of the bedroom, feathers, cottonseed (mattress), wool, toys and animal contacts, the environmental contacts in the rest of the house, occupational contacts of the parents, and environmental contacts about the house: factories, stables, barns. If it is confirmed by repeated observation that perennially the patient is worse when the wind blows from the west, what is located at a reasonable distance west of the home? If this effect is seasonal, pollen should be suspected.

The question of foods as a possible cause of the condition should be studied by means of a diet diary or elimination diet, as described in any of the current textbooks on allergy (Rowe, Tuft, Rackemann or Coca).

Regarding the negative skin reactions obtained, it is not indicated in the inquiry whether the tests were done by cutaneous or intracutaneous technic. The skin reactions at this age are, next to the history, of greatest importance. They are usually positive at this age but may require the intracutaneous technic for demonstration. Unless they have been performed in this manner, with materials known to be active, it cannot be said that the reactions were negative to the inhalants or pollens.

In cases in which these suggestions have been carried out without results, the room should be furnished in a manner to eliminate all environmental substances known to produce atopy. This may be done by encasing the pillows and mattress with rubberized material, sealing all seams. The furniture should not be upholstered but should consist of wood or cane, with no pads. Such substances as orris root, animal danders and wool (carpets, blankets) must be eliminated. Draperies and other accessories likely to gather dust should be removed. The child may then be kept in this room and clinical studies made by introducing the various suspected substances into the room one at a time during asthma free periods and the effects observed.

These are but a few suggestions for such study. Some of these problems are sufficiently difficult to defeat the efforts of the most carefully trained physician. However, the more one studies the history, the more likely will the result be successful.

POSSIBLE ARSENICAL HEPATITIS

To the Editor:—A white man aged 42, examined April 24, 1937, showed Kahn, Wassermann, Hecht-Gradwohl Wassermann and Laughlen tests positive 4 plus. A series of seventeen neoarsphenamine and seventeen bismuth injections were given, with severe reactions to the neoarsphenamine developing. These were followed by ten thio-bismol, six mapharsen, six bismuth and three tryparsamide injections. Because of severe reactions all arsenicals were discontinued in November 1937. Between that date and March 1939, forty-six injections of 0.2 Gm. of thio-bismol were given. Sept. 22, 1937, the Wassermann reaction was 4 plus and December 1 the Kahn reaction was 3 plus. Jan. 9, 1938, spinal puncture showed the colloidal gold curve negative, the Kahn reaction 2 plus, the Kline reaction 2 plus and the Rytz reaction negative. In September 1938 the blood Kolmer reaction was 3 plus. November 8, urinalysis was negative. The red blood count was 4,200,000, white blood count 10,400, hemoglobin 85 per cent, polymorphonuclears 75 per cent, lymphocytes 24 per cent. The Kahn reaction was 1 plus, cholesterol antigen 4 plus; Wassermann reaction weakly positive. Blood sugar was 94, blood urea 11, the icterus index 23, cholesterol 246, esters 132, 54 per cent. Total protein was 6.6, albumin 5.8, globulin 0.8, A/G 7.2. Spinal puncture gave a cell count of 0, globulin trace. The Levinson reaction was negative, colloidal gold curve 0000000000, cholesterol antigen and Wassermann reaction negative. Feb. 11, 1939, the bromsulphalein test resulted in less than 1 per cent retained in thirty minutes. With the galactose tolerance test, 0.5 Gm. was recovered in five hours. The icterus index was 6 as measured by extracting the serum with three volumes of absolute alcohol, refrigerating two hours, centrifuging and comparing with the dichromate standard. The physical examination at this time is entirely negative, with the exception of the slight jaundice. Is this jaundice, remaining fifteen months after the last dose of arsenic, due to arsenical hepatitis? What treatment is advisable at this time?

HENRY G. HADLEY, M.D., Washington, D. C.

ANSWER.—The data supplied in this inquiry do not permit a definite answer of the questions asked. The reported tests of liver function are all within normal limits, so that it would seem advisable to have a serum bilirubin estimation made and at the same time determine the amount of carotene in the blood. It might be that the patient's color is not due to jaundice.

If the serum bilirubin estimation is within normal limits, further treatment for the syphilis should be limited to two courses of bismuth compounds during the coming twelve months, ten injections to the course, and after that further treatment for syphilis would seem inadvisable irrespective of the blood serologic reports. Special examination for evidence of syphilitic disease of the aorta and periodic reexaminations each six months should be made.

If the serum bilirubin indicates the presence of jaundice, the inference is then possible that the patient has had some liver damage, probably from the arsenic, in which case all treatment for syphilis should be stopped. A high sugar and a low protein diet with reexamination every month or six weeks would be advisable. Most of the patients with postarsphenamine jaundice recover completely; if, however, the continued use of heavy metal such as bismuth does not help the involution, treatment for syphilis in such cases should be discontinued.

CEREBROSPINAL VASCULAR SCLEROSIS OR THE TABETIC FORM OF DEMENTIA PARALYTICA

To the Editor:—A white man aged 79 complains of incontinence and inability to walk. He has had some weakness during the past year. Two months ago he suddenly lost the ability to get up from a sitting position and was unable to walk unassisted. In bed at that time he became incontinent. After about a month he regained some control of the bladder and could walk without assistance. At no time has he been paralyzed. Muscle power seemed normal. He got along fairly well for several weeks, only to become bedridden again with the same complaints. The patient is unable to stand unassisted; his speech is disoriented occasionally and the family reports an antagonistic accusation attitude. All arm and leg muscles have normal power and there is no paralysis of the facial or any other muscles. There are no tremors. The radial reflex is the only positive reflex. Abdominal, biceps, patellar and plantar reflexes are normal. There is no clonus. Pressure, pain and temperature sense are intact. He is blind in the left eye. The right eye has a purulent discharge and remains closed for the most part, with only slight vision. He has had chronic ulceration in the nasal corner of the right eye for sixteen years. The fundi cannot be examined owing to lack of cooperation; the disks cannot be seen; the entire fundus seems red; the vessels are hard to discern. The patient complains of pain in the epigastrium and over the precordium. The blood pressure is 160 systolic, 80 diastolic; the pulse is 72, heart sounds are faint, only the aortic sounds being audible, and are normal, and there is no evidence of arteriosclerosis in the palpable arteries. There is tenderness in the epigastrium. The patient has no desire for food. I have not yet received an answer as to his Wassermann reaction. Would you discuss this case with the probable diagnosis or further aids to a proper diagnosis?

M.D., Maryland.

ANSWER.—From the history, which has a number of variable and unusual combinations of signs and symptoms, two conditions are suggested: One is cerebrospinal vascular sclerosis and the other is the tabetic form of dementia paralytica. If there is normal muscle power, there must be some evidence of defects of deep sensibility such as sensory ataxia and abnormality of bone and joint position and vibration sense. If the latter is present the patient has cerebrospinal syphilis of the tabetic type. It is possible and probable that the patient also has cerebral and spinal arteriosclerosis. This may result in a picture of pseudobulbar palsy. It is suggested that the following be done: reexamine the patient for sensory defects such as bone and joint position, vibration, touch, pain and temperature functions; dilate the pupils and examine the optic nerve heads. If there is a primary optic atrophy one can be fairly confident that one is dealing with the tabetic form of dementia paralytica. However, if retinal sclerosis is found with secondary atrophy the patient has arteriosclerotic atrophy causing the blindness. A cystoscopic examination should be done to determine the presence of a cord bladder. What is meant by disorientation in speech? Does the man have motor or sensory aphasia or both? The latter usually occurs in arteriosclerotic and hypertensive diseases of the brain and rarely if ever in the tabetic form of dementia paralytica.

ABSENT TEETH

To the Editor:—I was interested in a query headed "Absent Teeth and Delayed Dentition in Baby" in THE JOURNAL, February 25, page 766, because of the patient I saw at my office about this age. The child was brought in with the same complaint. Physical examination was negative in every way except for the absence of eyelashes and teeth. Because of the unusually narrow gingival margin, I took roentgenograms of the jaws and found the presence of only four tooth buds. That was five years ago, and since then the child has shown the presence of only four teeth. I am wondering whether the case presented to you by the doctor from Virginia is similar in character. In looking up the literature I found no case in which the absence of teeth has been diagnosed before the appearance of some of the teeth, but in the English literature there are a few cases reported which were discovered after the eruption of some of the teeth.

ABBOTT L. WINOGRAD, M.D., Nashua, N. H.

ANSWER.—The child mentioned in this query who as an infant showed only four tooth buds in the roentgenogram of the jaws and five years later has only four teeth, and in whom the absence of eyelashes is also noted, probably belongs to the group of cases collected under the title "hereditary ectodermal dysplasia." In the February 25 query it is noted that "x-ray examination of the skull shows unerupted teeth present. The film was not a good one." This information was rather indefinite, but by inference it was supposed that the tooth buds were present and that actual dentition was simply tardy. In the "hereditary ectodermal dysplasia" group there is frequently seen, along with the lack of development of most all of the teeth, other ectodermal defects, particularly of the skin, hair and nails, and there may even be absence of sweat glands. The absence of the eyelashes as noted in this query would make one suspect that this case belonged in that group. Kerley has recently reported such a case in which there was complete absence of all teeth. Several references related to this group are here listed:

Weech, A. A.: Hereditary Ectodermal Dysplasia, *Am. J. Dis. Child.* **37**: 766 (April) 1929.
Kerley, C. G.: Hereditary Ectodermal Dysplasia, *Arch. Pediat.* **55**: 211 (April) 1938.
Stein, J. L., and Gerber, Alexander: Congenital Absence of Teeth, *J. Pediat.* **13**: 547 (Oct.) 1938.

DISINFECTION OF THE SKIN

To the Editor:—Is it safe, after thorough scrubbing of the hands and arms and rinsing in sterile water, to immerse the hands and arms in compound solution of cresol? If so, what strength should be employed in preparation for an abdominal operation? The person in question is sensitized to both mercury bichloride and alcohol and seeks another safe means for preparation of the hands and arms.

M.D., Pa.

ANSWER.—Compound solution of cresol has strict limitations as a germicidal agent. With pure cultures of bacteria in vitro it may give good results but it cannot be relied on to disinfect the skin. On the skin it destroys "transient" bacteria readily but is much less effective against the "resident" bacteria. For discussion of these terms see the article by Philip B. Price (THE JOURNAL, Nov. 26, 1938, p. 1993).

Seventy per cent by weight alcohol is probably the most effective of available reagents for disinfecting the hands and arms. It is noted that in the inquiry the person in question is sensitive to alcohol. Most persons who regard themselves sensitive to alcohol base this opinion either on the use of 95 per cent alcohol or on the use of alcohol denatured by some irritating substance. It is suggested that the inquirer try 70 per cent by weight alcohol made with pure ethyl alcohol or alcohol denatured by the addition of boric acid only.

REFRIGERATOR GASES AND EYES

To the Editor:—Could you give me any information concerning antidotes used in the eyes against the various chemicals employed in electric refrigerators?

E. O. ALVIS, M.D., Indianapolis.

ANSWER.—Two chemical refrigerants, namely ammonia and sulfur dioxide, stand out as the chief sources of injury to the eyes. In addition to chemical action, actual freezing of a portion of the eye may result from a tiny jet of the chemical spurting into the eye. Ulceration may ensue in which chemical action may have a part. For the usual inflammatory injury to the eyes from ammonia, sulfur dioxide or conceivably the decomposition products of organic refrigerants, the immediate treatment is essentially the same. It is highly desirable that the injured eye be immediately and copiously laved with water. This may be followed by the introduction of saturated solution of boric acid. If pain is severe, the use of a local anesthetic such as 0.5 per cent solution of pontocaine hydrochloride is indicated. Thereafter, application of olive oil or some similar oil is desirable. Carbon dioxide is not known to produce injuries to the eyes except those resulting from freezing. A report by the Committee on Poisonous Gases was published in THE JOURNAL **94**:1832-1838 (June 7) 1930.

CHRONIC GONORRHEA AND SPERMATORRHEA

To the Editor:—A patient who had gonorrhea seven months ago seems cured so far as the urethra goes. In the last two months he has urinated a little too frequently in the daytime but rarely gets up nights to pass urine. There is a little burning. After having a stool he has developed the habit of pressing down as if to press more from the rectum but no stool passes; instead, a fluid passes from the urethra which looks a little like semen but shows no pus cells and few spermatozoa. I recognize nothing wrong in the prostate or in the seminal vesicles and analysis of the urine is negative. There are no strictures. I am wondering whether this is vesiculitis or a habit brought on by introspection. Can you suggest something that might help me clear the diagnosis—possibly a textbook.

M.D., Illinois.

ANSWER.—With the presence of frequency of urination and burning, it might be well to check the patient's prostate and seminal vesicles again by massage to make sure that the strippings are free of pus under the microscope. It is possible that the patient has a latent prostatitis or seminal vesiculitis—the remnants of the gonorrheal infection. Rectal examination is not sufficient in cases of this kind; therefore the prostate and vesicles should be stripped and the strippings examined. If the first examination is negative, two or three examinations should be made. If pus is found, the usual treatment such as massage, sitz baths and hot rectal irrigations is indicated. It might be

well to subject the patient to cystoscopy to rule out a lesion in the bladder, although this condition probably is remote.

It is possible that the patient has spermatorrhea. According to the statement made, he has developed the habit of "pressing down"; this pressure might act like massage and express the fluid from the seminal vesicles. The thing for the patient to do is to stop this habit of "pressing."

This subject is amply discussed in any of the standard textbooks on urology, such as those by Hinman, Keyes, Hermann, Hugh Cabot or Hugh Young.

SEROSANGUINEOUS DISCHARGE FROM UMBILICUS

To the Editor:—A girl aged 17 began last October having a serosanguineous discharge from the umbilicus four days after a regular menstrual period. The duration of the discharge is usually about fourteen days and it has occurred after every menstruation since the onset. The umbilicus has been examined repeatedly by myself and others, but no external opening can be found. The dressing has been sealed down over the umbilicus both with adhesive tape and with collodion, and always there is the same discharge on the dressing when it is changed. She states that on one occasion while this was going on she passed some blood in the urine. She was given methylene blue tablets and about forty-eight hours later a definite bluish tinge was found on the dressings on the umbilicus. She was roentgenographed after the bladder was filled with about 450 cc. of sodium iodide and the roentgenogram revealed a perfectly normal bladder without any connection with the umbilicus. Cystoscopic examination was also negative. No masses or swellings can ever be found about the umbilicus, and the pads, which are sometimes heavy with the discharge, do not have any odor. The patient has normal bleeding and clotting times and her blood picture is perfectly normal. In view of the fact that the bladder has been roentgenographed to rule out any connection with the umbilicus, that is, a patent urachus; that methylene blue stain was found on the pad after having been given by mouth; that there is no swelling around the umbilicus which would possibly signify an endometrial tumor; that there is no external opening for this discharge to come through, and since it has been sealed up to my satisfaction that the bloody discharge is not being put there from some other source, I would appreciate some help on this case. Am I dealing with some form of neurosis? Is it possible for this discharge to get through the skin without an external opening? Is methylene blue found in bloody discharges without any connection with the bladder? What else can I do to arrive at a diagnosis of this puzzling condition? Thank you for any help that you may be able to give me as to literature on similar conditions or as to suggestions on the best methods in handling this condition. W. C. MITCHELL, M.D., Smyrna, Ga.

ANSWER.—This is indeed a puzzling case. There appear to be two separate conditions. In spite of the absence of a palpable tumor at the umbilicus there is most likely an area of endometriosis on the peritoneal surface of the umbilicus or near it. Even though no opening is visible in the umbilicus, there is almost certainly a tiny opening present, if not at all times then only at the time when the serosanguineous discharge appears at the umbilicus. Otherwise it is impossible to explain a blood-tinged discharge after each menstrual period. Since no mention is made of any abdominal operation or any adhesion between the uterus and the abdominal wall, there is almost certainly no direct connection betwen the uterus and the umbilicus.

The presence of methylene blue at the umbilicus after the ingestion of this substance by mouth signifies that there is a connection betwen the urinary tract and the umbilicus. This may be a patent urachus.

The patient should have a complete study made of the urinary tract, including an intravenous pyelogram, and perhaps also instillation of methylene blue in the bladder to see whether any will appear at the umbilicus.

The entire case is puzzling, and the physician should make certain that the patient is not malingering. The greatest authority on the umbilicus is T. S. Cullen, whose monumental book "The Umbilicus" should be studied for additional information.

TISSUE CHEMISTRY AND AGE

To the Editor:—Osler has been quoted to the effect that aging is a process of increasing tissue acidosis. Is there any chemical proof of this? Have any comparative studies been made of the *p*H of tissue and blood, calcium phosphorus ratio, alkali reserve, and the like in childhood, youth, maturity and old age? B. A. FEDDE, M.D., Brooklyn.

ANSWER.—There is no good evidence that increased tissue acidosis goes hand in hand with increased age. Extensive comparative studies on tissues and blood at different ages do not appear to have been made. In general, with increased age there is a tendency to a lower content of water in nerve tissue and probably also in other tissues. The serum of adults contains higher concentrations of proteins than that of infants. The blood volume also increases per square meter of body surface area, with an increase up to adult age. However, the blood volume per kilogram of body weight decreases as adulthood is reached. None of these changes would lead to a decrease in alkali reserve.

LATE CLOSURE OF FONTANELS

To the Editor:—Will you kindly answer the following questions: 1. Is it true that the poet Dryden's fontanel did not close until he was 27 years old? 2. Are there other such examples of the late closing of the fontanel? 3. Does it indicate anything other than a probable case of rickets? 4. Could late closure of the fontanel be associated with some other condition—congenital syphilis, for example—which would impair mentality or distort personality? 5. What would be the present day treatment for such a condition? 6. Is there any one who makes a hobby of seventeenth century medicine?

CLARENCE W. LIEB, M.D., Tucson, Ariz.

ANSWER.—1. After considerable search in various libraries no information could be obtained as to the failure of the poet Dryden's fontanel to close until he was 27 years old. 2. In a cretin the fontanel may remain open beyond the usual time of closing, which is eighteen months; however, failure of closing of the fontanel after the twenty-fifth year must be an extremely rare condition. 3. Rickets delays ossification of normally formed cartilage. In severe renal rickets the fontanel does not remain open for any considerable length of time beyond that of normal closure. 4. Congenital syphilis is not usually associated with the late closing of the fontanel; this could, however, impair mentality or distort personality, as there are well authenticated cases of juvenile dementia praecox reported. 5. Present day treatment would depend on correct diagnosis. 6. There are probably some men who have made a hobby of seventeenth century medicine.

ASTHMA AND HERNIOTOMY

To the Editor:—A patient with chronic asthma (chronic allergic bronchitis) has developed an indirect inguinal hernia. Can you give me data on herniorrhaphy in asthmatic patients with regard to mortality and end results? WALTER I. WERNER, M.D., Albuquerque, N. M.

ANSWER.—There are two factors to be considered in reply to this query. One is the effect of a hernia operation on the asthmatic state and the other is the effect of the asthma on the herniotomy. In the majority of patients with asthma the asthmatic condition adds but little hazard to the surgical operation. There is a possibility, of course, of pulmonary complications, particularly massive pulmonary atelectasis. This can be minimized by the avoidance of preoperative and postoperative use of morphine and by hyperventilation of the lungs immediately after the operation. Local anesthesia also diminishes that possibility. On the other hand, operative procedures frequently have a beneficial effect on the asthmatic state for a period varying from a few weeks to a few months. The asthma itself with the chronic cough, of course, will add some increased possibility of a recurrence of the hernia. No statistical data with special reference to end results and mortality rate of herniorrhaphy in asthmatic individuals have been found.

SMALLPOX VACCINATION TECHNIC

To the Editor:—One of our best medicos here, who enjoys being different, is advising his patients to return six or seven days after being vaccinated to have the "blister" picked and dressed. It looks surgically sound to me. I would appreciate a discussion of this question in Queries and Minor Notes. M.D., Texas.

ANSWER.—The practice of treating the vesicle formed after vaccination for smallpox by surgical manipulation and dressing is not recommended by the various authors contributing authoritative essays on the subject. This procedure is not included in the manual of the United States Public Health Service under the description given for the technic and directions for vaccination against smallpox.

PETIT MAL

To the Editor:—In your issue of April 29, page 1752, there is a letter on petit mal. I would like to express my disagreement with the statement that "petit mal epilepsy does not respond to any drug treatment." I have seen a number of patients who were much benefited by phenobarbital and recently I have seen very gratifying results from the use of diphenylhydantoin. In some cases in which neither drug worked alone, the use of three small doses of diphenylhydantoin during the day and one dose of phenobarbital at night had a conspicuously beneficial effect. I agree that in children the ketogenic diet is often better than drugs.

The term "pyknolepsy" is in my opinion overrated as an entity. I do not believe that it is anything more than a subvariety of epilepsy. One cannot divide these clinical types of seizures into anything like as simple a classification as grand mal, petit mal, pyknolepsy and equivalents. There are all sorts of intergradations between these four, and the arbitrary division obscures the biologic significance of the interrelationships.

Incidentally, there has recently been a tendency to use the term "petit mal epilepsy." I might point out that petit mal is always epilepsy, so the latter word is redundant. STANLEY COBB, M.D., Boston.

Medical Examinations and Licensure

COMING EXAMINATIONS

NATIONAL BOARD OF MEDICAL EXAMINERS SPECIAL BOARDS

Examinations of the National Board of Medical Examiners and Special Boards were published in THE JOURNAL, June 17, page 2557.

STATE AND TERRITORIAL BOARDS

ARIZONA: Phoenix, July 5-6. Sec., Dr. J. H. Patterson, 826 Security Bldg., Phoenix.

CALIFORNIA: *Written examinations.* San Francisco, July 10-13, Los Angeles, Aug. 7-10, and Sacramento, Oct. 16-19. *Oral examinations* (required when reciprocity application is based on a state certificate or license issued ten or more years before filing application in California), Los Angeles, August 7, and San Francisco, Nov. 15. Sec., Dr. Charles B. Pinkham, 420 State Office Bldg., Sacramento.

COLORADO. Denver, July 10-12. Sec., Dr. Harvey W. Snyder, 831 Republic Bldg., Denver.

CONNECTICUT: *Medical (Regular).* Hartford, July 11-12. *Endorsement.* Hartford, July 25. Sec., Dr. Thomas P. Murdock, 147 W. Main St., Meriden. *Medical (Homeopathic).* Derby, July 11-12. Sec., Dr. Joseph H. Evans, 1488 Chapel St., New Haven.

DELAWARE: Dover, July 11-13. Sec., Medical Council of Delaware, Dr. Joseph S. McDaniel, 229 S. State St., Dover.

DISTRICT OF COLUMBIA: *Basic Science.* Washington, June 26-27. *Medical.* Washington, July 10-11. Sec., Commission on Licensure, Dr. George C. Ruhland, 203 District Bldg., Washington.

HAWAII: Honolulu, July 10-13. Sec., Dr. James A. Morgan, 48 Young Bldg., Honolulu.

IDAHO: Boise, Oct. 3-4. Dir., Bureau of Occupational License, Mr. H. B. Whittlesey, State Capitol Bldg., Boise.

ILLINOIS: Chicago, Oct. 17-19. Superintendent of Registration, Department of Registration and Education, Mr. Homer J. Byrd, Springfield.

IOWA: *Basic Science.* Des Moines, July 11. Dir., Division of Licensure and Registration, Mr. H. W. Grefe, State Department of Health, Capitol Bldg., Des Moines.

MAINE: Augusta, July 11-12. Sec., Board of Registration of Medicine, Dr. Adam P. Leighton, 192 State St., Portland.

MASSACHUSETTS: Boston, July 11-13. Sec., Board of Registration in Medicine, Dr. Stephen Rushmore, 413-F State House, Boston.

MONTANA: *Reciprocity.* Helena, Oct. 2. *Examination.* Helena, Oct. 3-4. Sec., Dr. S. A. Cooney, 216 Power Block, Helena.

NEBRASKA: *Basic Science.* Lincoln, Oct. 3-4. Dir., Bureau of Examining Boards, Mrs. Clark Perkins, 1009 State Capitol Bldg., Lincoln.

NEVADA: *Reciprocity and oral examination.* Carson City, August 7. Sec., Dr. John E. Worden, 311 W. Robinson St., Carson City.

NEW HAMPSHIRE: Concord, Sept. 14-15. Sec., Board of Registration in Medicine, Dr. T. P. Burroughs, State House, Concord.

NEW MEXICO: Santa Fe, Oct. 9-10. Sec., Dr. Le Grand Ward, 135 Sena Plaza, Santa Fe.

NEW YORK: Albany, Buffalo, New York, and Syracuse, June 26-29. Chief, Bureau of Professional Examinations, Mr. Herbert J. Hamilton, 315 Education Building, State Education Department, Albany.

NORTH DAKOTA: Grand Forks, July 5-8. Sec., Dr. G. M. Williamson, 4½ S. Third St., Grand Forks.

OKLAHOMA: Oklahoma City, Dec. 13. Sec., Dr. James D. Osborn, Jr., Frederick.

OREGON: *Basic Science.* Corvallis, July 8, and Portland, Oct. 28. Sec., State Board of Higher Education, Mr. Charles D. Byrne, University of Oregon, Eugene.

PENNSYLVANIA: *Written.* Philadelphia and Pittsburgh, beginning July 5. *Bedside.* Philadelphia, July 7-8. Dir., Bureau of Professional Licensing, Dr. James A. Newpher, 358 Education Bldg., Harrisburg.

PUERTO RICO: Santurce, Sept. 5. Sec., Dr. O. Costa Mandry, Box 3854, Santurce.

RHODE ISLAND: Providence, July 6-7. Sec., Dr. Robert M. Lord, 366 State Office Bldg., Providence.

SOUTH CAROLINA: Columbia, June 27. Sec., Dr. A. Earle Boozer, 505 Saluda Ave., Columbia.

SOUTH DAKOTA: Rapid City, July 18-19. Director, Medical Licensure, Dr. G. J. Van Heuvelen, State Board of Health, Pierre.

UTAH: Salt Lake City, June 26-28. Dir., Department of Registration, Mr. G. V. Billings, 326 State Capitol Bldg., Salt Lake City.

WEST VIRGINIA: Bluefield, July 5. Sec., Public Health Council, Dr. Arthur E. McClue, State Capitol, Charleston.

WISCONSIN: Milwaukee, June 27-30. Sec., Dr. Henry J. Gramling, 2203 S. Layton Blvd., Milwaukee.

Illinois April Examinations

Mr. Homer J. Byrd, superintendent of registration, Illinois Department of Registration and Education, reports the written examination (graduates of foreign schools given also a practical test) held in Chicago, April 11-13, 1939. The examination covered ten subjects and included 100 questions. An average of 75 per cent was required to pass. Thirty-nine candidates were examined, thirty-four of whom passed and five failed. The following schools were represented:

School	PASSED	Year Grad.	Per Cent
Northwestern University Medical School		(1938)	78, 87,* (1939) 80, 82, 82, 83, 83, 84, 85, 87
Rush Medical College		(1937)	80, 84, (1938) 83, 85
University of Illinois College of Medicine		(1937)	81, 85, (1938) 83
Harvard Medical School		(1932)	80
University of Minnesota Medical School		(1937)	83
Jefferson Medical College of Philadelphia		(1937)	86
University of Pennsylvania School of Medicine		(1937)	84
Marquette University School of Medicine		(1936)	79
University of Toronto Faculty of Medicine		(1928)	82, (1936) 89
University of Western Ontario Medical School		(1937)	84
Medizinische Fakultät der Universität Wien		(1923)	78
Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin		(1908) 82, (1922)	75
Ludwig-Maximilians-Universität Medizinische Fakultät, München		(1924) 78, (1936)	81
Rheinische Friedrich-Wilhelms-Universität Medizinische Fakultät, Bonn.		(1938)	81
Regia Università degli Studi di Roma. Facoltà di Medicina e Chirurgia		(1933)	76
Universität Bern Medizinische Fakultät		(1937)	76,* 82

School	FAILED	Year Grad.
Medizinische Fakultät der Universität Wien		(1936)
Univerzita Komenského Fakulta Lekárska, Bratislava		(1934)
Albert-Ludwigs-Universität Medizinische Fakultät, Freiburg		(1922)
Universität Köln Medizinische Fakultät		(1922)
Regia Università degli Studi di Roma. Facoltà di Medicina e Chirurgia		(1937)

Eighteen physicians were successful in the practical examination for reciprocity and endorsement applicants held in Chicago, April 13. The following schools were represented:

School	PASSED	Year Grad.	Reciprocity with
Rush Medical College		(1937)	Louisiana
Indiana University School of Medicine		(1933)*	Indiana
State University of Iowa College of Medicine		(1931)	Iowa
University of Kansas School of Medicine		(1927)*	Kansas
Harvard Medical School		(1934)	Penna.
Wayne University College of Medicine		(1935)	Michigan
University of Minnesota Medical School		(1934), (1937)	Minnesota
St. Louis University School of Medicine		(1933), (1936)	Missouri
Washington University School of Medicine		(1932)	Missouri
Western Reserve University School of Medicine		(1937)	Ohio
Meharry Medical College		(1937)	Tennessee
University of Tennessee College of Medicine		(1937)	Tennessee

School	PASSED	Year Grad.	Endorsement of
College of Medical Evangelists		(1935)	N. B. M. Ex.
Northwestern University Medical School		(1938)	N. B. M. Ex.
Rush Medical College		(1937)	N. B. M. Ex.
Medical College of the State of South Carolina		(1936)*	N.B.M.Ex.

*License has not been issued.

Maine March Examination

Dr. Adam P. Leighton, secretary, State of Maine Board of Registration of Medicine, reports the written examination held at Portland, March 14-15, 1939. The examination covered ten subjects and included 100 questions. An average of 75 per cent was required to pass. Twelve candidates were examined, ten of whom passed and two failed. Two physicians were licensed by reciprocity and one physician was licensed by endorsement after an oral examination. The following schools were represented:

School	PASSED	Year Grad.	Per Cent
Boston University School of Medicine		(1937)	81
Harvard Medical School		(1936)	82
Tufts College Medical School		(1922) 79, (1938)	78
University of Michigan Medical School		(1937)	83
University of Minnesota Medical School		(1937)	85
University of Rochester School of Medicine		(1937)	82
Hahnemann Medical College and Hospital of Philadelphia		(1938)	81
Regia Università degli Studi di Roma. Facoltà di Medicina e Chirurgia		(1935)	78
Universität Basel Medizinische Fakultät		(1937)	81

School	FAILED	Year Grad.	Per Cent
Georg August-Universität Medizinische Fakultät, Göttingen		(1919)	74
National University of Athens School of Medicine		(1935)	53

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
Tufts College Medical School		(1936)	New Hamp.
Regia Università degli Studi di Roma. Facoltà di Medicina e Chirurgia		(1936)	Maryland

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
University of Pennsylvania School of Medicine		(1934)	N. B. M. Ex.

Missouri Reciprocity and Endorsement Report

Dr. Harry F. Parker, secretary, State Board of Health of Missouri, reports seven physicians licensed by reciprocity and one physician licensed by endorsement at the meeting held in Excelsior Springs, April 10, 1939. The following schools were represented:

School	LICENSED BY RECIPROCITY	Year Grad.	Reciprocity with
University of Arkansas School of Medicine		(1930), (1937)	Arkansas
Rush Medical College		(1934)	W. Virginia
Tulane University of Louisiana School of Medicine		(1937)	Louisiana
University of Tennessee College of Medicine		(1936), (1937), (1938)	Tennessee

School	LICENSED BY ENDORSEMENT	Year Grad.	Endorsement of
St. Louis University School of Medicine		(1935)	N. B. M. Ex.

Book Notices

English, German, French, Italian, Spanish Medical Vocabulary and Phrases. By Joseph S. F. Marie. Foreword by Chevalier Jackson, M.D., Sc.D., LL.D., Honorary Professor of Broncho-Esophagology and Consultant in Broncho-Esophagologic Research, Temple University School of Medicine, Philadelphia. Cloth. Price, $3. Pp. 358. Philadelphia: P. Blakiston's Son & Co., Inc., 1939.

Here is the kind of book that has been wanted by many physicians, namely an English, German, French, Italian and Spanish medical vocabulary with useful phrases. Dr. Chevalier Jackson says that it makes him sad to think of the thousands of weary hours that he might have saved had he had a book of this type available. In alphabetical form the book lists some thousands of terms in English with German, French, Italian and Spanish equivalents. At the end, as supplements, there are sections on pronunciation and also a series of phrases such as might be needed by the physician in making an examination or in giving directions.

Valutazione biologica dei medicamenti. Dal Dott. Prof. Giulio Bucciardi del Laboratorio Farmacologico Dr. Recordati, Correggio. Cloth. Price, 120 lire. Pp. 561, with 70 illustrations. Florence: G. C. Sansoni, 1938.

It is perfectly correct, as stated by Dr. Recordati in his introducation to this book, that "We need not only in Italy but elsewhere a manual which contains practical descriptions in detail of the methods for the bio-assay of medicinal preparations." This is especially true of a book on the subject so thoroughly abreast of the times as this one. It is most interesting to note that the bio-assay of drugs, which until recent years was the chief concern of books on this subject, occupies merely one fourth of this book. The rest is taken up with the bio-assay of hormones, vitamins and antiserums. Very valuable also is the "general part," which includes a discussion of equipment for bio-assay, general directions for it, and a brief exposition of statistical methods as applied to it. Our Italian confrères are to be congratulated on the possession of this book, the acquisition of which can be unreservedly recommended to bio-assay laboratories in other parts of the world, even if they need to engage a translator.

Report of the Medical Research Council for the Year 1937-1938. Presented by the Lord President of the Council to Parliament by Command of His Majesty February 1939. Paper. Price, $1.05. Pp. 221. New York: British Library of Information; London: His Majesty's Stationery Office, 1939.

It is impossible to do justice in the space available to the extensive field of investigation covered by this report. Actual promotion of specific research by the Medical Research Council is usually done by appointment of individuals to the permanent staff. Such appointments depend on the subject which seems to require special attention and on the merits of the persons chosen. When once appointed, an individual has wide liberty of action in planning investigation. The council seldom chooses particular diseases for investigation but it designed to include the study of etiologic factors common to a group of diseases, a type of treatment of wide application or a system of physiologic or biochemical control. Examples now under investigation are virus diseases, endocrinology and chemotherapy. Another part of the work of the council consists of personal and expense grants, the initiative in choice of subject and method of investigation lying with the head of a laboratory or hospital or with the worker himself. An important duty of the Medical Research Council since its beginning has been to help government departments confronted with immediate problems of health and disease. The National Institute for Medical Research has a large staff at work on important investigations related to virus diseases, transmissible tumors, lung cancer and dust, chemotherapy, endocrinology and other broad problems. The Institute for Medical Research also carries out extensive work on the standardization of biologic products in a manner in some respects similar to that of the U. S. Bureau of Standards. There are a number of clinical research units staffed and supported by the council in several recognized institutions. All these have been producing important investigation for a considerable period and include such well known units as the Clinical Research Unit, Guy's Hospital and the Department of Clinical Research at the University College Hospital, London, under the direction of Sir Thomas Lewis. The council has also made an important contribution by grants-in-aid for medical research and is active in research in tropical medicine and in industrial health. In all, the report reflects many of the advantages of centralized direction without dictation of actual research problems. It may be recommended to the careful perusal of all those interested in the advance of scientific medicine.

Thus We Are Men. By Sir Walter Langdon-Brown, M.A., M.D., LL.D., Consulting Physician to St. Bartholomew's Hospital, London. Cloth. Price, $3.50. Pp. 344. New York: Longmans, Green & Co., 1939.

Among the most erudite and clever of British writers in the field of medicine today is Sir Walter Langdon-Brown, emeritus professor of physic and fellow of the Corpus Christi College in the University of Cambridge. This series of lectures comprises such important addresses as the Maudsley, the Cavendish and the Sir Charles Hastings memorial lecture. There are also the contributions to the Harveian Society, the Abernethian Society and the Osler Club. Every one of the essays is thought provoking and mentally stimulating. There are many quotable paragraphs. For example, "In disease of the body the higher levels which develop last suffer first, for they have not had time to acquire such a firm hold on the instincts of the organism as the lower. In the same way the body politic evolves its higher levels later than the individuals composing it. A committee is always more ready to perpetrate an injustice than its individual members would be."

The first lecture, on "The Biology of Social Life," reveals a penetrating analysis of present international relationships from the biologist's point of view. In the essay entitled "The Return to Aesculapius" there are some profound thoughts on the basis for quackery. Here are some interesting concepts regarding Christian science and osteopathy. The author's reading has been wide and he seems familiar with the important notes from here and there throughout the world.

The biographic essays which concern Osler and Robert Bridges are inspiring, and there is a chapter on "The Psychology of Authorship" which reveals an erudition far beyond that of most physicians. Unusual is the essay on "The Evolution of Death," and the final essay, "Retrospect," ends with the following philosophy: "It is sometimes well to realize, as life goes on, that we must leave things to younger men to accomplish. We may see a new truth but be too set in our ways to ensue it. It is well to be able to say 'The life to which I belong uses me and will pass beyond me, and I am content.'"

The Evolution of Obstetric Analgesia. By Andrew M. Claye, M.D., F.R.C.S., F.C.O.G., Professor of Obstetrics and Gynaecology, University of Leeds. With a chapter by W. Stanley Sykes, M.A., M.B., B.Ch., Honorary Anaesthetist, General Infirmary at Leeds. Cloth. Price, $2. Pp. 103, with 5 illustrations. New York, Toronto & London: Oxford University Press, 1939.

The author wrote this book because "no English volume solely on the subject has stressed its historical aspect." He discusses the two main landmarks, the introduction of ether and chloroform into obstetrics by Simpson and the elaboration of twilight sleep by Gauss. Likewise he expresses his own ideas concerning the scopolamine-morphine technic, which he learned from Gauss in Würzburg in 1931. There are also chapters on scopolamine amnesia, the barbiturates and more inhalation anesthetics, nitrous oxide and ethylene, the last written by W. Stanley Sykes. Claye says "We have on my suggestion aimed at giving some form of analgesia to every patient in labor. . . . This, as regards inhalation anesthetics, is carried out almost entirely by medical students and . . . the work has been in the great majority of cases conscientiously and efficiently done." In the United States, medical students are rarely permitted to give inhalation anesthetics. Claye further remarks "I think . . . it is much safer for the doctor to give the anesthetic, which he should be competent to do, and for the nurse to take the delivery, which she should be competent to do. The reverse process is not uncommon." Of course the author refers to nurses who have had good training in obstetrics and who are nurse midwives. In this country inhalation anesthetics are nearly always administered by doctors or nurses who are especially trained in inducing anesthesia. This small book contains nothing new.

Apparently the author regards Gauss as of equal importance with Simpson in the field of obstetric analgesia and anesthesia (he uses these terms interchangeably). He includes photographs of both men. The chapter on twilight sleep, which contains Gauss's name innumerable times, is longer than the chapter devoted to Simpson.

Out of the Running. By G. Gertrude Hoopes. With a foreword by Edgar A. Doll, Ph.D., Director of the Department of Research, The Training School at Vineland, New Jersey, and with clinical notes by Winthrop M. Phelps, M.D., Director of the Children's Rehabilitation Institute, Inc., Baltimore. Cloth. Price, $2. Pp. 158, with 4 illustrations. Springfield, Illinois, & Baltimore: Charles C. Thomas, 1939.

Gertrude Hoopes is in many ways far from being "out of the running," though she is severely handicapped by infantile cerebral palsy. Practically unable to walk, she gets about on a specially constructed tricycle; unable to talk, she has evolved a shorthand sign language and joins conversations by pointing to letters of the alphabet. Despite her handicaps, she has lived a very active life and has enjoyed the friendship of many cultured and prominent persons. Throughout the book one is continually reminded that through her religious faith she was able to conquer feelings of depression and morbidity which would assail her when she contemplated how different her life was from that of the normal person. So strong were these feelings that on two occasions she attempted suicide, but so strong has her belief in religion become that never since has the thought of suicide troubled her. Infantile cerebral palsy is the most neglected of all crippling conditions, and the goal in working with handicapped persons is to educate and train them so that they may return to society and find a place in life. It evidently has not been necessary for Miss Hoopes to earn her own living, but if it were she could probably develop her writing ability to the extent of becoming financially independent. It is regrettable that Miss Hoopes has not included a purely objective chapter in her book. It is partially the objective treatment of Helen Keller's life that makes her biography remarkable, since it shows definitely how the blind and deaf may overcome their handicaps and become useful citizens. When medicine and surgery fail to aid the blind and the deaf, special education steps in to help them cross the physical barriers. Neither surgery nor medicine has contributed a great deal to Miss Hoopes's happiness. Her physical barriers have been crossed by her determination and refusal to become discouraged and by her ingenious devices, such as the tricycle and her clever method of carrying on a conversation. Her story therefore should arouse a greater interest in promoting special education in cases of infantile cerebral palsy.

The Chemistry of the Carbon Compounds. By Victor von Richter. Edited by the late Prof. Richard Anschütz. Volume II: The Alicyclic Compounds and Natural Products. Translated from the XIIth German edition and revised by T. W. J. Taylor, M.A., Fellow and Tutor of Brasenose College, Oxford, and A. F. Millidge, Ph.D., B.Sc. Third edition. Cloth. Price, $15. Pp. 656. New York: Nordemann Publishing Company, Inc.; Amsterdam: "Elsevier," 1939.

This volume will be welcomed not only by the investigator in chemistry but also by many others, particularly as a source of information on chemistry. It is a companion to volume 1 and, like it, needs no introduction to the chemist. The scope of the volume is broad, correlating an enormous amount of organic material, including the alicyclic series and natural products, such as glucosides, natural coloring substances, vitamins and hormones.

Registro e interpretación de la actividad cardíaca. Por Oscar Orias, professor de fisiología y director del Instituto de fisiología de la Facultad de ciencias médicas de Córdoba (República Argentina). Third edition. Paper. Pp. 199, with 81 illustrations. Buenos Aires: Librería y editorial "El Ateneo," 1939.

This excellent short, beautifully illustrated monograph on the graphic methods of recording the heartbeat has had a deserved popularity, as evidenced by a third edition in a few years. The material is based in part on the work of Wiggers and his school, which includes the author, and in part on the further work which the author did on his return to South America. The material is presented in its application to clinical conditions. It is encouraging to know that such fundamental work is being disseminated among the Spanish speaking members of the medical profession.

Clinical Bacteriology. By F. A. Knott, M.D., M.R.C.P., D.P.H., Director, Bacteriological Department, Guy's Hospital. Cloth. Price, $4.50. Pp. 426, with 60 illustrations, including 12 plates. Philadelphia: P. Blakiston's Son & Co., Inc., 1939.

This small book was written for the purpose of impressing the reader with the clinical significance of bacteriologic phenomena. There are no references to the literature in the text, and the public health aspects represent the practices in Great Britain rather than those in this country. There are many inaccuracies in the book. For example, in the discussion on tularemia the author states that "the disease has so far been met with only in America." Tularemia was reported in Japan in 1925, Russia in 1928, Norway in 1929, Sweden in 1931 and Austria in 1935. The last chapter deals with normal flora of the body. An appendix includes material on bacteriologic culturing, staining and serologic methods and the preparation of bacterial vaccines and two pages on fungous infections. The illustrations and plates are excellent. This book can be recommended for the physician's library but is inadequate for the medical student.

Die Arzneikombinationen. Von Professor Dr. Emil Bürgi. Paper. Price, 12 marks. Pp. 169, with 28 illustrations. Berlin: Julius Springer, 1938.

The author quotes an ancient Babylonian inscription, "To give a medicine the desired quality, it must be combined of at least two active substances that through suitable quantitative relations antagonize each other's harmful effects while they mutually increase their desired action." It remained for Bürgi, the author of this book, to codify this 4,000 year old proposition and to publish it in 1909 in the form of his well known "law" or, better, rule, which may be formulated thus: Substances that have the same final effect have, when combined, additive action if they have the same point of attack and a superadditive effect when they have a different pharmacologic mode of action. This rule is true not only of drugs but also of nonmedicinal measures and of combinations of these two, e. g. mountain climate and iron in the treatment of anemia. In the present book the author discusses under the various therapeutic headings the facts and the literature that have accumulated proving the validity of his "law." To all who are interested in efficient therapy this book can be highly recommended. It is indispensable for teachers of pharmacology and therapeutics.

Olla Podrida: Piquant Spanish Dishes from the Old Clay Pot. By Elinor Burt. Cloth. Price, $3. Pp. 277. Caldwell, Idaho: Caxton Printers, Ltd., 1938.

With many Americans, enjoyment of Spanish cooking is more of a novelty than a fad. The author of this volume has had cooperation from many leading experts in the development of the book, including Spanish students, and has had also a year of work in the Bureau of Home Economics in Washington, D. C. The book contains not only brief essays discussing the nature of the special cooking of Spanish, Mexican, Creole and Latin-American types but also a number of interesting recipes.

Chemical Analysis for Medical Students: Qualitative and Volumetric. By R. E. Illingworth, Ph.D., B.Sc., Lecturer in Chemistry, School of Medicine of the Royal College, Edinburgh. With a foreword by G. Barger, ScD., LL.D., F.R.S., Regius Professor of Chemistry, University of Glasgow, Glasgow. Cloth. Price, $1.50. Pp. 152, with one illustration. Baltimore: William Wood & Company, 1938.

For this textbook, primarily intended for first year medical students, the subject matter was selected at Edinburgh medical schools with the hope that it might be of value in other similar institutions. The volume will be of value to those interested in qualitative analysis and will prove useful.

Personality Development and Social Control in Terms of Constitution and Culture. By Ira S. Wile, M.S., M.D. Three Lectures at The Tavistock Clinic, July 1937. Paper. Price, $1.25. Pp. 57. New York & London: Oxford University Press, 1939.

This is a collection of three lectures given by the author at the Tavistock Clinic in July 1937 entitled "Personality in Terms of Constitution," "Personality in Relation to Culture" and "Social Control and the Prevention of Personality Disorders." As might be expected, they reflect the broad culture and philosophical and medical background of the author.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Accident Insurance: Scarlet Blotch on Skin as "Visible Contusion or Wound."—The defendant issued an insurance policy providing double indemnity if "the death of the insured occurred . . . as a result, directly and independently of all other causes, of bodily injuries, effected solely through external, violent and accidental means, of which, except in case of drowning or of internal injuries revealed by an autopsy, there is a visible contusion or wound on the exterior of the body." The insured was found dead on the floor of a garage about 2 feet from the exhaust pipe of an automobile. There were scarlet blotches on his face, trunk and extremities, indicative that death was due to carbon monoxide poisoning. From a judgment allowing recovery under the policy, the defendant insurance company appealed to the United States circuit court of appeals, seventh circuit.

The insurance company denied liability, contending that the scarlet blotches were not a "contusion or wound" within the meaning of the policy. It is true, answered the court, that, etymologically, "contusion" suggests an injury which is the result of the impact of a blow on the exterior of the body. The purpose of the policy, however, in conditioning liability on the presence of a "visible contusion or wound on the exterior of the body" was to have visible, physical evidence of the operation of the "external, violent and accidental means," which are alleged to have effected the bodily injuries. "Visible contusion," as used in the policy, included, the court thought, any morbid change in or injury to either the subcutaneous tissue or the skin which produces markings or discolorations visible on the exterior of the body. It is not material whether the "visible contusion" results directly from the operation of the "means" on the exterior of the body or indirectly from the internal injuries which are effected by the action of the "means." The accidental operation of external means may be wholly internal, and yet the internal injuries may extend to the subcutaneous tissue or into the layers of the skin. The visibility of the "contusion" may be due to the discoloration either of the injured tissue under the skin or of the injured skin itself, or of both. The scarlet blotches on the exterior of the body of the insured were caused by the action of the carbon monoxide and were connected with the "internal injuries" which resulted in the death of the insured. When carbon monoxide is inhaled into the lungs it passes into the blood and combines with the hemoglobin contained in the red blood cells. As a result, tissue cells are deprived of an adequate supply of oxygen. This, in turn, causes the death and decomposition of tissue cells, which results in the appearance of scarlet blotches on the exterior of the body. The court held, therefore, that the scarlet blotches were visible contusions or wounds within the meaning of the policy and the judgment against the insurance company was affirmed.—*Warbende v. Prudential Ins. Co. of America, 97 F. (2d) 749.*

Accident Insurance: Amebic Dysentery Not a Bodily Injury Sustained Through Accidental Means.—The defendant insurance company insured Burns "against bodily injuries sustained . . . solely and independently of all other causes through accidental means." A sewer pipe broke in a hotel in which Burns was registered and contaminated the drinking water with amebae. Burns contracted amebic dysentery as a result of drinking the water and eventually died. In a suit which Burns' beneficiary subsequently instituted on the policy the trial court entered a judgment for the insurance company on the pleadings. The beneficiary appealed to the court of appeals of Ohio, which reversed the cause and remanded it to the trial court, but a motion to certify the record to the Supreme Court of Ohio was allowed.

The question to be determined, said the Supreme Court, is whether a death from amebic dysentery contracted from drinking contaminated water is the result of a bodily injury sustained by accidental means. Generally an accident is considered as an event proceeding from an unexpected happening or unknown cause without design and not in the usual course of things. The court found no difficulty in holding that Burns' death was due to amebic dysentery which was accidentally contracted. The amebae contaminated the water by an accident, the breaking of the sewer pipe. It was likewise accidental that they entered Burns' system. A more difficult question was whether or not the contraction of amebic dysentery was a bodily injury. There was, said the court, no violence, vis major, or other casualty which operated directly on Burns. Many courts have held that deaths or disabilities resulting from the mechanical action of food or drink, ptomaine poisoning, alcoholic poisoning, infections of the eye by gonococci, blood poisoning, carbon monoxide poisoning, typhoid and from "drinking milk of cows which had eaten golden rod" were due to a bodily injury within the terms of insurance policies containing provisions somewhat similar to the policy involved in this case. The Supreme Court, however, was not impressed with these decisions. Those cases, said the court, proceeded on the theory that the policy under question must be construed most strongly against the insurer, whose duty it was to exclude specifically the risks if there was doubt. But a court should not resort to a construction never conceivably intended by the parties.

To uphold the theory of recovery in this case, continued the court, would be to hold that all diseases are bodily injuries. There would thus be no difference between an accident policy and a health policy, except insofar as it would be necessary, to recover on an accident policy, to trace the cause to some mischance. In the present case, the policy was not a general health policy but a limited accident policy, and the premium collected was for a limited coverage. Bodily injury should be considered as limited to bodily injuries resulting from physical or external forces known as accidents. Pneumonia, typhoid, scarlet fever and the like are diseases due solely to germs. To call them bodily injuries is to establish a new nomenclature and classification not generally used in ordinary conversation. The words "bodily injury" are commonly and ordinarily used to designate an injury caused by external violence, and they are not used to indicate disease. The court believed that the words "bodily injury" as used in this policy were used in their common and accepted meaning and that to create liability there must be evidence of some external or violent and accidental force or cause. No such evidence was present in this case. The court accordingly affirmed the judgment of the trial court directing a verdict in favor of the insurer.—*Burns v. Employers' Liability Assur. Corporation, Limited, of London, England (Ohio), 16 N. E. (2d) 316.*

Society Proceedings

COMING MEETINGS

American Association for Thoracic Surgery, Los Angeles, July 5-7. Dr. Richard H. Meade Jr., 2116 Pine St., Philadelphia, Secretary.
American Physiotherapy Association, Denver, June 25-30. Mrs. Eloise T. Landis, 2065 Adelbert Road, Cleveland, Secretary.
American Proctologic Society, Brooklyn, N. Y., June 25-27. Dr. Curtice Rosser, 710 Medical Arts Bldg., Dallas, Texas, Secretary.
Maine Medical Association, Poland Springs, June 25-27. Dr. F. R. Carter, 22 Arsenal St., Portland, Secretary.
Medical Library Association, Newark, N. J., June 27-29. Miss Janet Doe, 2 East 103d St., New York, Secretary.
Montana, Medical Association of, Butte, June 28-30. Dr. Thomas L. Hawkins, 50 North Main St., Helena, Secretary.
National Medical Association, New York, Aug. 15-19. Dr. John T. Givens, 1108 Church St., Norfolk, Va., General Secretary.
National Tuberculosis Association, Boston, June 26-29. Dr. Charles J. Hatfield, 50 West 50th Street, New York, Secretary.
Pacific Coast Oto-Ophthalmological Society, San Francisco, June 19-22. Dr. C. Allen Dickey, 450 Sutter St., San Francisco, Secretary.
West Virginia State Medical Association, White Sulphur Springs, July 10-12. Mr. Joe W. Savage, Public Library Bldg., Charleston, Executive Secretary.

Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1929 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but may be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

Titles marked with an asterisk (*) are abstracted below.

American Heart Journal, St. Louis

17: 387-514 (April) 1939

Coronary Sclerosis: Analysis of 928 Cases. B. J. Clawson, Minneapolis.—p. 387.

Blood Oxygen Changes Following Intermittent Venous Occlusion. J. R. Veal, Washington, D. C., and W. M. McCord, New Orleans.—p. 401.

Normal Heart Volume in Man. G. Liljestrand, E. Lysholm, G. Nylin and C. G. Zachrisson, Stockholm, Sweden.—p. 406.

Follow-Up Study of Systolic Murmurs. M. J. Shapiro, Minneapolis.—p. 416.

Transient Bundle Branch Block and Other Electrocardiographic Changes in Pulmonary Embolism. T. M. Durant, I. W. Ginsburg and H. Roesler, Philadelphia.—p. 423.

Tumors of Heart and Pericardium. R. W. Scott and C. F. Garvin, Cleveland.—p. 431.

Premature Closure of Foramen Ovale: Report of Two Cases. Miriam Crowell Benner, Denver.—p. 437.

Coarctation of Aorta, Nonclinical Type, Associated with Congenitally Bicuspid Aortic Valve: Method for Its Recognition, with Report of Case. P. Hallock and R. Hebbel, Minneapolis.—p. 444.

*Nonrheumatic Calcific Aortic Stenosis. C. K. Friedberg and A. R. Sohval, New York.—p. 452.

Development of Electrocardiogram of Embryonic Heart. E. C. Hoff, New Haven, Conn.; T. C. Kramer, Ann Arbor, Mich.; D. DuBois, New Haven, Conn., and B. M. Patten, Ann Arbor, Mich.—p. 470.

Nonrheumatic Calcific Aortic Stenosis.—Friedberg and Sohval review the clinical features of fifteen necropsy cases of calcific aortic stenosis in which the possibility of a rheumatic etiology had been previously excluded. As a corollary they attempted to determine whether it was clinically possible to differentiate the rheumatic from the nonrheumatic cases. The differentiation of calcific aortic stenosis from coronary artery disease may be extremely difficult because the symptoms of both are due essentially to myocardial ischemia. Attacks of dizziness and syncope, when present, favor a diagnosis of calcific aortic stenosis rather than arteriosclerotic heart disease. If, in addition, there is a distinctive murmur or a systolic thrill, the differentiation from coronary artery disease is clear. Calcific aortic stenosis should be considered as a diagnostic possibility in any patient with cardiac failure of obscure etiology. The differentiation of rheumatic from nonrheumatic calcific aortic stenosis usually cannot be made from the symptoms and physical signs alone. If the patient is less than 50 years of age, the aortic stenosis is usually due to rheumatic fever. When the physical signs of mitral stenosis are uncertain, x-ray evidence of unusual left auricular or right ventricular enlargement suggests associated rheumatic mitral disease. Similarly, if the electrocardiogram shows right ventricular preponderance, due apparently to mitral disease, the calcific aortic stenosis is probably rheumatic.

American Journal of Cancer, New York

35: 491-656 (April) 1939

Morphologic Resemblance of Pulmonary Adenomatosis (Jaagsiekte) in Sheep and Certain Cases of Cancer of Lung in Man. C. Bonne, Batavia, Java, Netherlands Indies.—p. 491.

Effect of Freezing in Vitro on Some Transplantable Mammalian Tumors and on Normal Rat Skin. G. B. Mider and J. J. Morton, Rochester, N. Y.—p. 502.

Contributions to Tissue Culture Technic. J. P. M. Vogelaar and Eleanor Erlichman, New York.—p. 510.

Primary Liver Cell Carcinoma with Splenic Metastases. A. F. Liber and C. R. Brown, New York.—p. 521.

Reticulum Cell Sarcoma of Spleen. M. Gerundo and M. B. Miller, Topeka, Kan.—p. 528.

Carcinoma of Kidney in Rats Treated with Beta-Anthraquinoline. A. Sempronj and E. Morelli.—p. 534.

Production of Lung Tumors in Mice by Intratracheal Administration of Carcinogenic Hydrocarbons. M. B. Shimkin, Cambridge, Mass.—p. 538.

Effect of 1,2,5,6-Dibenzanthracene on Growth and Respiration of Yeast. E. S. Cook Sr., Mary Jane Hart and R. A. Joly, Cincinnati.—p. 543.

Vitamin E and Experimental Tumors. C. Carruthers, Iowa City.—p. 546.

*Statistical Relation Between Goiter and Cancer. J. F. McClendon, Minneapolis.—p. 554.

Goiter and Cancer.—McClendon discusses the possibility of some causal relation between goiter and cancer. It seems possible that a single thyroid cell might break loose and traveling in the blood stream either disintegrate, or, finding a favorable environment in the wall of the alimentary tract, undergo a metamorphosis and become the starting point of a supposedly primary cancer of the alimentary tract. Another possible causal relationship between goiter and cancer is that the thyroid hormone causes differentiation of cells. Deficiency of this hormone might permit some cells to remain undifferentiated and therefore potentially precancerous. The author presents statistics and states that, although they may not be regarded as entirely sufficient to establish a relation between goiter and cancer, the evidence is quite conclusive that thyroid adenoma may predispose to cancer of the thyroid and is an ample warning that goiter may constitute a danger of increasing the cancer rate. Therefore goiter prophylaxis with iodine in the young and desiccated thyroid in the aged may be a precaution worth taking to prevent an increase in the incidence of cancer.

Annals of Internal Medicine, Lancaster, Pa.

12: 1555-1738 (April) 1939

Observations on Treatment of Lipoid Nephrosis. R. H. Major, Kansas City, Kan.—p. 1555.

Renal Threshold for Glucose; Clinical Observations on Case of Nondiabetic (Renal) Glycosuria. H. M. Thomas Jr. and H. Southworth, Baltimore.—p. 1560.

Importance to the Internist of Latent Paranasal Sinusitis. G. H. Lathrope, L. A. Peer and R. Paddock, Newark, N. J.—p. 1576.

Acute Insufficiency of Adrenal Glands: Report of Two Cases. A. L. Burger and H. Fink, Brooklyn.—p. 1583.

Studies of Iron Metabolism in Case of Hemochromatosis. A. Marble and Rachel M. Smith, Boston.—p. 1592.

Nature of Arterial Hypertension, with Special Reference to the Role of the Kidney. M. Prinzmetal, Los Angeles; B. Friedman, New York, and D. I. Abramson, Brooklyn.—p. 1604.

Vasomotor Effects of Blood in Patients with Hypertension and Animals with Experimental Hypertension. B. Friedman, New York, and M. Prinzmetal, Los Angeles.—p. 1617.

*Tropical and Nontropical Sprue (Chronic Idiopathic Steatorrhea): Their Probable Interrelationship. A. M. Snell, Rochester, Minn.—p. 1632.

Gold Therapy in Arthritis: Observations on 100 Cases Treated with Gold Sodium Thiosulfate and Aurocein. R. G. Snyder, C. Traeger and L. Kelly, New York.—p. 1672.

Rightward Deviation of Axis of the T Wave as Index of Myocardial Disease. R. Ashman and Eleanor H. Hidden, New Orleans.—p. 1682.

Tropical and Nontropical Sprue.—Snell reports thirty-two cases of "nontropical" sprue or "idiopathic steatorrhea" affecting residents of the Central and North Central states. Also fourteen cases of sprue contracted in the tropics are reviewed. The cases of nontropical sprue differ from tropical sprue chiefly by virtue of their extreme chronicity and an associated tendency to disturbed calcium metabolism and skeletal deformities. The common features of the thirty-two cases of nontropical sprue were glossitis and stomatitis, emaciation, fatty diarrhea, various types of anemia, disturbances of the metabolism of calcium and of protein, and a group of symptoms related to various vitamin deficiencies. There are no definite prodromal symptoms of nontropical sprue, although certain patients who later had the classic disease gave a history of chronic remittent gastrointestinal disturbances, nausea, vomiting, anorexia, intolerance to food and intestinal irritability. Physical examination revealed a most striking degree of malnutrition with muscular wasting and cachexia. Twenty patients presented symptoms and signs which were virtually identical with those seen in tropical sprue; in these patients there was a definite beneficial response to liver extract. The remaining twelve patients presented various metabolic and nutritional disturbances, including tetany, osteoporosis, hypoproteinemia and various vitamin deficiencies. The condition in these cases was identical in all respects to that described in the English and Scandinavian literature as "idiopathic steatorrhea." The response to liver extract in these cases was often unsatisfactory but, in certain cases in which the patients were adequately treated, good results were obtained. Since the sprue syndrome is not uncommon in temperate climates its earlier recognition and treatment would largely eliminate the late "complicated" cases.

Archives of Neurology and Psychiatry, Chicago

41: 871-1086 (May) 1939

Histopathologic Changes in Nervous System in Cases of Peptic Ulcer. A. R. Vonderahe, Cincinnati.—p. 871.
*Remissions in Multiple Sclerosis. Madelaine R. Brown and T. J. Putnam, Boston.—p. 913.
Symmetric Cerebral Calcification, Particularly of Basal Ganglions, Demonstrable Roentgenographically: Calcification of Finer Cerebral Blood Vessels. L. M. Eaton, J. D. Camp and J. G. Love, Rochester, Minn.—p. 921.
*Sequelae of Postmeasles Encephalomyelitis: Clinicopathologic Study. N. Malamud, Ann Arbor, Mich.—p. 943.
Encephalopathy Following Anesthesia: Histologic Study of Four Cases. A. T. Steegmann, Cleveland.—p. 955.
Korsakoff's Syndrome: Clinical Study of Alcoholic Form, with Special Regard to Prognosis. M. Rosenbaum and H. H. Merritt, Boston.—p. 978.
Extrapyramidal System: Experimental Demonstration of Function. F. A. Mettler, H. W. Ades, E. Lipman and E. A. Culler, Augusta, Ga.—p. 984.
Experimental and Clinical Study of Effects of Metrazol Convulsions. E. A. Strecker, B. J. Alpers, J. A. Flaherty and J. Hughes, Philadelphia.—p. 996.
Occurrence of Pick's Disease in Early Adult Years. K. Löwenberg, D. A. Boyd Jr. and D. D. Salon, Ann Arbor, Mich.—p. 1004.
Easily Made Apparatus for Use in "Closed System" Pneumo-Encephalography, with Notes on Technic for Its Use. W. L. Holt Jr. and R. S. Schwab, Boston.—p. 1021.

Remissions in Multiple Sclerosis.—Brown and Putnam present their observations in 133 cases of multiple sclerosis, ninety-five of which were observed in the wards of the neurologic unit and thirty-eight were seen in office practice. There was a striking difference between the course of the illness in the two groups. Periods of improvement were reported in thirty-three of the thirty-eight and in only fifty-nine of the ninety-five. In all, 550 separate symptoms were recorded in the 133 cases. The report covers 1,095 "patient years" of the disease. During the period under consideration, 239 instances of improvement were reported by ninety-two of the 133 patients. In the others the disease was uninterruptedly progressive or stationary after a single attack. Ambulatory patients seen in "office" practice were found to have a significantly longer and milder course with more remissions than those seen in "hospital" practice. In general, symptoms evidently due to small lesions, such as diplopia, central scotoma or sensory disturbances of one extremity, tend to regress within a few months. Symptoms apparently due to large lesions, such as paraplegia, ataxia and mental deterioration, are usually permanent. As a rule, isolated symptoms disappear in a far higher proportion of instances than do the same symptoms occurring in conjunction with others. Symptoms tend to grow more severe as the disease progresses. Most lesions of multiple sclerosis go through an acute stage, after which a variable number of fibers regain the ability to conduct impulses. Certainly in most large lesions, and probably in all lesions, there is permanent destruction of the conductivity of some or many fibers.

Sequelae of Postmeasles Encephalomyelitis.—Malamud reports two cases which illustrate the sequelae of postmeasles encephalomyelitis and he traces the manner in which this terminal condition develops from the preceding acute and subacute stages. Such an investigation, he states, may also be of value in differentiating disseminated encephalomyelitis from multiple and diffuse sclerosis, concerning which there is considerable confusion in the literature. The permanent sequelae of postmeasles encephalomyelitis were characterized in one case by predominantly hemiplegic manifestations and in the other case by hyperkinesis, personality change, mental enfeeblement and ataxia. Such symptoms, according to Ford, are frequent complications of this disorder. In the first case the development of the neurologic disturbance during the prodromal period of measles does not contradict the diagnosis. In the second case the hyperkinetic syndrome closely resembled the disturbances following epidemic encephalitis in childhood. The clinical course was not progressive; the symptoms remained stationary and in the first case they even partially receded. The lesions in the two cases were localized exclusively in the white matter and occurred in three predilective sites: (1) perivascularly (perivenously) within the white substance of the cerebrum and cerebellum, (2) subependymally in the vicinity of the ventricles and (3) marginally in the spinal cord. Histologically, the lesions were poorly outlined coalescing foci of demyelination, in which myelin sheaths and axis cylinders were equally destroyed. They were uniformly replaced by dense glial scars devoid of any signs of inflammation. Fundamental differences between disseminated encephalomyelitis and multiple and diffuse sclerosis are outlined.

Archives of Ophthalmology, Chicago

21: 731-912 (May) 1939

Bilateral Endophthalmitis Complicating Pneumococcic Septicemia: Report of Case. J. Reber and H. G. Scheie, Philadelphia.—p. 731.
Rickettsia Question in Trachoma: I. Microscopic Observations on Virus. A. E. Braley, Iowa City.—p. 735.
Naevus Flammeus Associated with Glaucoma: Report of Case. M. H. Pincus, Brooklyn.—p. 741.
Angioid Streaks. A. Hagedoorn, Amsterdam, Netherlands.—p. 746.
Circulatory Disturbances in Retina in Arteriosclerosis and in Essential Arterial Hypertension. H. Elwyn, New York.—p. 775.
Primary Glioma of Optic Nerve: Report of Case. C. W. Rand, R. Irvine and D. L. Reeves, Los Angeles.—p. 799.
Production of Corneal Ulcers in the Rabbit. R. McDonald and H. Pettit, Philadelphia.—p. 817.
*Congenital Familial External Ophthalmoplegia Without Ptosis, with Lesion of Pyramidal Tract. M. Helfand, New York.—p. 823.
Bilateral Iritis Complicating Serum Sickness. F. H. Theodore and A. C. Lewson, New York.—p. 828.
Streak Retinoscopy. W. Z. Rundles, Flint, Mich.—p. 833.
Hodgkin's Disease of Lid: Report of Case. D. Kravitz, Brooklyn.—p. 844.
Unilateral Papilledema: Its Significance and Pathologic Physiology. E. G. Smith, Lancaster, Pa.—p. 856.

Congenital Familial Ophthalmoplegia.—Helfand reports a case of congenital familial external ophthalmoplegia without ptosis associated with involvement of the right side of the pyramidal tract. He believes that the most important contribution to the etiology of this condition has been derived from studies in embryology. The embryopathophysiologic theory explains the ocular disturbances in these cases. It not only is supported by clinical data but can be verified by experimental procedures (Bagg and Little). The involvement of the right side of the pyramidal tract in the case reported, the author states, becomes intelligible in the light of the experiments of Bagg and Little. These authors constantly found the occurrence of ocular anomalies together with deformities of the extremities, for the abnormal bleb was usually retained on the dorsal side of the organism and nearly always around the anlage of the eyes and the extremities. It is also plausible that a mechanical hindrance in the form of an abnormal bleb situated at the cephalic flexure might injure the anlage of the motor tract and spare the sensory system. These interferences usually occur in embryos of about 7 or 8 mm., or at the fourth or fifth week of embryonic life, at which time the sensory anlage is already ripened and is therefore more resistant to pressure.

Delaware State Medical Journal, Wilmington

11: 51-70 (April) 1939

Control of Venereal Disease from a State and National Point of View. R. A. Vonderlehr and Josephine Hinrichsen, Washington, D. C.—p. 51.
Evolutionary Perspective of Syphilis. R. C. Holcomb, Upper Darby, Pa.—p. 59.

Georgia Medical Association Journal, Atlanta

28: 143-182 (April) 1939

Infectious Mononucleosis: Report of Case. A. H. Bunce and M. S. Dougherty Jr., Atlanta.—p. 143.
Amnesia in Obstetric Practice: Study of Sodium Pentobarbital (Nembutal) Scopolamine and Sodium Propyl-Methyl-Carbinyl-Allyl Barbiturate (Seconal) Scopolamine. H. C. Frech Jr., Savannah; P. P. Volpitto and R. Torpin, Augusta.—p. 147.
*Use of Cevitamic and Nicotinic Acid in Edema of Nephrosis: Preliminary Report of Cases. J. W. Daniel, Savannah.—p. 154.
Angina Pectoris and the Coronary Arteries. H. C. Atkinson, Macon.—p. 157.
Pneumoperitoneum: Adjunct to Treatment of Pulmonary Tuberculosis: Report of Nineteen Cases. A. W. Hobby, Atlanta.—p. 159.
Quackery in Georgia 100 Years Ago. J. Krafka Jr., Augusta.—p. 163.
Postsulfanilamide Agranulocytosis: Report of Case with Recovery. B. J. Hoffman, Atlanta.—p. 166.
Modern Concepts in Industrial Medicine. C. W. Roberts, Atlanta.—p. 167.

Ascorbic and Nicotinic Acid for Edema of Nephrosis.—Daniel reports the rapid correction of the edema of nephrosis of two patients following the administration of ascorbic and nicotinic acids. This leads him to believe that the disappearance of albuminuria and the increase of plasma proteins is not a period of remission which sometimes occurs in nephrosis but is brought about by the administration of the vitamins. He thinks that it is possible that the renal lesion may have a basic

vitamin shortage instead of being entirely the result of infection. In applying this treatment of edema in these cases he based the prognosis on laboratory and physical observations: normal nonprotein nitrogen, normal renal function test, the absence of erythrocytes in the urine, normal blood pressure and normal cardiac action.

Indiana State Medical Assn. Journal, Indianapolis

32: 233-298 (May) 1939

Pitfalls in the Diagnosis and Treatment of Clinical Allergy. B. Kraft, Indianapolis.—p. 233.
Prophylactic Program for Treatment of Allergic Diseases. C. B. Bohner, Indianapolis.—p. 236.
Allergy in Relation to Eczema. W. W. Duemling, Fort Wayne.—p. 237.
Allergy in Ear, Nose and Throat Practice. H. A. Kuhn, Hammond.—p. 241.
Emotional Factors in Skin Diseases. F. Gastineau, Indianapolis.—p. 244.
Nasal and Ocular Allergy. C. E. Savery, South Bend.—p. 247.
Obstetrics in General Practice: Consideration of Causes of Maternal and Fetal Mortality. C. P. Huber, Indianapolis.—p. 249.
Blood Banks and Blood Preservation. M. Bizer, Lafayette.—p. 261.
Tuberculosis in Childhood. Indiana Pediatric Society.—p. 264.

Journal of Immunology, Baltimore

36: 255-338 (April) 1939

Second Stage of Agglutinative Reaction. A. S. Wiener and M. Herman, Brooklyn.—p. 255.
Studies on Fibrinolysin Produced by Hemolytic Streptococcus. J. M. Jablonowitz, New York.—p. 261.
Sensitization of Guinea Pigs to Amidopyrine. A. Golden and H. W. Gierson, St. Louis.—p. 277.
Preparation and Properties of Aqueous Suspensions of Oil-Coated Tubercle Bacilli. E. Hehre, New York.—p. 285.
*Immunologic Studies in Active Vaccination Against Scarlet Fever. M. M. Strumia, with technical cooperation of Linden Crawford, Betty Bergh and Regina N. Neher, Bryn Mawr, Pa.—p. 301.
Effect of Volume of Antigen Solution on Its Rate of Absorption. T. B. Bernstein, S. S. Rubin and S. M. Feinberg, Chicago.—p. 309.
Endotoxin from Aspergillus Fumigatus. A. T. Henrici, Minneapolis.—p. 319.

Vaccination Against Scarlet Fever.—Strumia investigated the benefits to be expected from vaccination against scarlet fever, employing the scarlet fever streptococcus toxin. He finds that vaccination with scarlet fever streptococcus toxin sufficient to change a Dick-positive reaction to a negative one does not influence in any definite way the content in immune bodies of the serum as far as the fibrinolysins, agglutinins and streptolysins are concerned. Of the thirty-six cases in which determinations of antifibrinolysin and antistreptolysin were carried out before and after vaccination, there was agreement in twenty-five cases. In the other cases the variations before and after vaccination did not agree. A brother and sister in whom toxic hemolytic streptococci were cultured from the throat before the vaccination was begun showed high titer with both antifibrinolysin and hemolysin, which did not change with the vaccination. One of these children was Dick positive and the other Dick negative. In a control group of eight healthy adults studied over a similar period the antifibrinolysin titer showed no change in five, was decreased in one and was increased in two. In the same adult group the antistreptolysin showed no change during the period of observation, all but one being in the normal group. Since the observations were conducted during the late winter and early spring, when streptococcic infections of the upper respiratory passages are common, certain variations in the antistreptococcus properties are to be expected.

Journal Industrial Hygiene & Toxicology, Baltimore

21: 155-204 (May) 1939

Further Observations on Possible Systemic Toxicity of Certain Chlorinated Hydrocarbons with Suggestions for Permissible Concentrations in Air of Workrooms. C. K. Drinker, Boston.—p. 155.
Toxic Effects on Rabbits of Pentachlorphenol and Sodium Pentachlorphenate. R. A. Kehoe, W. Deichmann-Gruebler and K. V. Kitzmiller, Cincinnati.—p. 160.
*Toxicology of Some Glycols and Derivatives. E. P. Laug, H. O. Calvery, H. J. Morris and G. Woodard, Washington, D. C.—p. 173.
Note on Improved Cell for Dust Counting. K. L. Dunn, Corning, N. Y.—p. 202.

Toxicology of Some Glycols.—Laug and his co-workers determined the relative acute toxicities of some glycols and their derivatives and they found that the order of increasing toxicities is as follows: propylene glycol, diethylene glycol, ethylene glycol, diethylene glycol mono-ethyl ether, dioxan and ethylene glycol mono-ethyl ether. Rats, mice and guinea pigs were used for the tests. The rabbits, in comparison with other species, were found to have the lowest lethal dose for diethylene glycol, 50 per cent of them being killed. In fact, the lowest dose that killed some rabbits was the same as the estimated average dose that killed 105 persons. The lethal dose killing 50 per cent of animals in cubic centimeters per kilogram for mice is as follows: propylene glycol 23.9, diethylene glycol 23.7, ethylene glycol 13.1, diethylene glycol mono-ethyl ether 6.58, dioxan 5.66, ethylene glycol mono-ethyl ether 4.31 (concentrated) and 5.2 (diluted); for rats, propylene glycol 21, diethylene glycol 14.8, ethylene glycol 5.5, diethylene glycol mono-ethyl ether 5.54, dioxan 5.17, ethylene glycol mono-ethyl ether 3.46, and for guinea pigs, propylene glycol 18.9, diethylene glycol 7.76, ethylene glycol 7.35, diethylene glycol mono-ethyl ether 3.87, dioxan 3.9 and ethylene glycol mono-ethyl ether 2.79. It seems that small doses of propylene glycol can be safely tolerated by the animal body since it can be oxidized and probably converted to a normal body constituent. In this respect it resembles ethyl alcohol and glycerin. In larger quantities all these substances are toxic and, with the exception of propylene glycol, produce definitely demonstrable tissue injury. After correlating the information in the literature with the results of these experiments, the authors conclude that ethylene glycol, diethylene glycol, ethylene glycol mono-ethyl ether, diethylene glycol mono-ethyl ether and dioxan should be entirely omitted from food and drug preparations and that propylene glycol should be avoided except in minute concentrations.

Journal of Nervous and Mental Disease, New York

89: 625-756 (May) 1939

Treatment of Schizophrenia with Cardiazol in Convulsant Doses. H. Delgado, Lima, Peru.—p. 625.
Experiences in Use of Encephalography. R. Wartenberg, San Francisco.—p. 640.
Intracranial Chondroma: Case Report. M. I. Green and J. H. Childrey, San Francisco.—p. 650.
Hemiatrophy of the Brain. B. J. Alpers and R. B. Dear, Philadelphia.—p. 653.
Attitude of the Psychoneurotic Toward Scientific Contraceptive Advice. J. H. Friedman, New York.—p. 672.
Genoscopolamine: Its Use in Parkinsonism. J. H. Scharf, New York; assisted by Stephane T. Manong.—p. 682.

Journal of Thoracic Surgery, St. Louis

8: 351-468 (April) 1939

Lobectomy and Pneumonectomy in Pulmonary Tuberculosis. J. C. Jones and F. S. Dolley, Los Angeles.—p. 351.
Formation and Development of Primary Tubercle in Lung. W. S. Lemon, Rochester, Minn.—p. 371.
*Bronchopleural Fistulas Complicating Pulmonary Tuberculosis: Clinical Pathologic Study. O. Auerbach and S. Lipstein, New York.—p. 384.
Late Results of Lobectomy for Bronchiectasis in Children. J. V. Bohrer and C. W. Lester, New York.—p. 412.
Mechanics of Pulmonary Abscess, Pulmonary Gangrene and Bronchiectasis, with Suggested Method of Treatment. M. Joannides, Chicago.—p. 427.
Aspiration Biopsy of Tumors of Lung. L. F. Craver and J. S. Binkley, New York.—p. 436.

Bronchopleural Fistulas and Tuberculosis.—Auerbach and Lipstein state that in 1,000 consecutive necropsies in chronic ulcerative pulmonary tuberculosis seventy-eight cases of bronchopleural fistulas were found. Fifteen of the bronchopleural fistulas occurred in previously uncollapsed lungs, fifty-six in the presence of an artificial pneumothorax and seven as a direct result of closed pneumonolyses. The size of the fistula at necropsy varied from 1 mm. to 4 cm. and 73 per cent were present in the upper lobes of the lung. The fistulas were diagnosed clinically in fifty-two cases. Bronchopleural fistulas occurring within six months after the induction of artificial pneumothorax usually ended in a fulminating caseous pneumonia. The underlying pulmonary pathologic condition in cases of bronchopleural fistulas occurring after from one to four years of pneumothorax therapy was that of a chronic pulmonary tuberculosis. Empyemas were present in all but five instances. In these the fistulas developed too soon before death for fluid to collect. Mixed infection empyemas were recorded in twenty-seven instances, tuberculous empyemas occurred in seventeen and the remaining patients either had no aspirations or the reports were inadequate. Healing of bronchopleural fistulas may be temporary or permanent. It may occur because the visceral pleura becomes adherent to the parietal pleura in the region of the perforation or a fibrinous exudate, which later is organized into fibrous tissue, may seal off the opening.

Kentucky Medical Journal, Bowling Green

37: 129-176 (April) 1939

Cancer of Breast. H. H. Hagan, Louisville.—p. 129.
*Analysis of 6,872 Admissions to the Louisville City Hospital Having Positive Syphilis Serologic Reports, 1928-1937 Inclusive. E. C. Humphrey, J. R. Hendon and F. M. Melton, Louisville.—p. 135.
Syphilis Control, the Medical Problem. F. W. Caudill, Louisville.—p. 138.
Modern Anesthesia. E. W. Northcutt, Covington.—p. 144.
Peritonitis: Recent Advances and Treatment. G. Y. Graves, Bowling Green.—p. 148.
Waldeyer's Ring. M. C. Baker, Louisville.—p. 152.
Now and Then in Ophthalmology. A. O. Pfingst, Louisville.—p. 157.
Enucleation with Glass Ball Implantation. E. C. Ellett, Memphis, Tenn.—p. 161.
Postpartum Care. S. S. Parks, Lexington.—p. 163.

Syphilis.—Humphrey and his associates state that of 6,872 hospital admissions between 1928 and 1937 in which there were positive Wassermann or Kahn reactions, representing 4,517 patients, there were 6,881 syphilitic diagnoses. This is not a study of a syphilis clinic or dispensary but of persons admitted to a general hospital in the majority of whom syphilis was an incidental finding and had nothing to do with admission to the hospital. From this analysis the incidence of syphilis among the general admissions to the Louisville City Hospital was found to be 13.1 per cent in the Negro patients and 4.1 per cent in the white patients. The proportion of men who have positive Kahn reactions in both races is about the same as that of women. The greatest incidence of syphilis occurred in early adult life. There was a much higher incidence of neurosyphilis and cardiovascular syphilis in men than in women in both races. There was a high relative incidence of cardiovascular syphilis in Negro men and of neurosyphilis in white men. More than 60 per cent of the patients had no record of being treated for venereal disease. Only a small percentage of those treated have had adequate treatment. A system has been instituted which provides for persons with incidental positive Kahn reactions. They are incorporated into the regular venereal clinic and followed just as though they had come in because of syphilis.

Laryngoscope, St. Louis

49: 239-322 (April) 1939

Physiology of Larynx: Résumé and Discussion of Literature for 1938. J. J. Pressman, Los Angeles.—p. 239.
Operative Procedure for Relief of Stenosis in Double Abductor Paralysis of Larynx. A. G. Rawlins, San Francisco.—p. 260.
Melanocarcinoma of Hard Palate. I. Arons, New York.—p. 271.
Clinical Significance and Treatment of Otogenous Facial Paralysis. H. Brunner, Chicago.—p. 276.
Plastic Surgery in Prague, Czechoslovakia: Recent Experiences. M. R. Guttman, Chicago.—p. 291.
Infection, Arthritis and Allergy. L. C. Boemer, St. Louis.—p. 297.

Medical Annals of District of Columbia, Washington

8: 97-126 (April) 1939

Some Thoughts on the Theories and Treatment of Drug Addiction. L. Kolb, Washington.—p. 97.
Office Routine for Treatment of Early Toxemias of Pregnancy and Borderline Cases. L. L. Cockerille, Washington.—p. 103.
Chorio-Angioma of Placenta: Review and Report of Case. J. Kotz and M. S. Kaufman, Washington.—p. 106.
*Routine Treatment of Gonorrhea in Females—Nonantiseptic Method: Supplementary Report. B. Notes, Washington.—p. 111.
Problems Confronted in Treatment of Oxyuriasis. H. A. Monat, Washington.—p. 112.

Treatment of Gonorrhea in Women.—Notes states that in August 1933 treatment of gonorrhea in women was begun by creating a local reaction and drainage with the omission of antiseptics: 1. All cervices with functioning cervical glands were cauterized one or more times with the electrocautery at intervals of two or more months in order to cause local reaction and to elicit better drainage of the active focus. 2. The urethral meatus and cervix were treated weekly with applicators saturated with 25 per cent silver nitrate in order to cause local reaction and to favor better drainage. 3. Douches of 1.5 per cent acetic acid (vinegar or physiologic) were taken by the patient at home twice daily with a fountain syringe until the cervix was healed and with a pressure syringe (bulb type) after the cervix was healed. Of 3,394 women with gonorrhea admitted as new cases to the gynecologic section of the Social Hygiene Clinic of the District of Columbia 705 were discharged as cured by the foregoing method. The author concludes that antiseptics should be abandoned in the treatment of gonorrhea in women and that every patient who cooperates can be cured.

Michigan State Medical Society Journal, Lansing

38: 273-364 (April) 1939

Geriatrics. C. D. Camp, Ann Arbor.—p. 289.
Thyroid Gland and Function of Reproduction. R. D. Mussey, Rochester, Minn.—p. 295.
Herpes Zoster Ophthalmicus: Case. A. D. Beam and V. L. Lindberg, Detroit.—p. 301.
Sulfanilamide. G. B. Myers, Detroit.—p. 302.
Etiologic Factors in Noninstitutional Patients with Epilepsy. L. E. Himler, Ann Arbor.—p. 315.
*Epilepsy as a Prison Problem: Its Treatment with Sodium Diphenylhydantoinate. D. P. Philips, Jackson.—p. 317.
Diverticulitis with Spontaneous Internal Evacuation of Abscess: Report of Case. L. S. Fallis and C. S. Martin, Detroit.—p. 320.
Cervicitis as Cause of Sterility, Abnormal Bleeding and Pelvic Pain. R. S. Siddall, Detroit.—p. 323.
Examining the Intoxicated Driver. P. W. Kniskern, Grand Rapids.—p. 325.
Spectacular Response of Acute Gonorrhea to Large Doses of Sulfanilamide. W. S. Martin, Ludington.—p. 328.
Medical Economic Problems. W. P. Woodworth, Detroit.—p. 331.

Sodium Diphenylhydantoinate for Epilepsy.—About a year ago Philips states that fourteen epileptic prisoners at the State Prison of Southern Michigan were given sodium diphenylhydantoinate as an anticonvulsant. The drug, 0.1 Gm., was given three times a day before meals. The seizures of all but one patient were controlled by this regimen. This one patient continued to have infrequent grand mal attacks at night and his dose was increased to 0.4 Gm. daily, that is he also received 0.1 Gm. of the drug at 11 at night. With the additional dose of the drug there have been no further convulsions. None of the patients had previously obtained any benefit from phenobarbital in large doses. On sodium diphenylhydantoinate therapy the convulsive seizures have ceased and behavior and attitudes have improved. As yet there is no indication that the effectiveness of sodium diphenylhydantoinate is lost or diminishes with time. The depression which characterizes patients taking large doses of phenobarbital is noticeably absent with the use of sodium diphenylhydantoinate. The drug appears to offer a new hope of assistance in rehabilitation because of its ability to control epileptic seizures without a hypnotic effect.

New England Journal of Medicine, Boston

220: 617-650 (April 13) 1939

Bronchoscopic Dilation of Bronchial Stenosis Following Thoracoplasty for Tuberculosis. E. B. Benedict, Boston.—p. 617.
Arachnodactyly: Its Occurrence in Several Members of One Family. J. Harrison and M. J. Klainer, Boston.—p. 621.
*Determination of Serum Phosphatase and Its Clinical Significance. J. M. Looney, Worcester, Mass.—p. 623.
Pulmonary Moniliasis. J. J. Decker, Boston.—p. 626.
Tumors of Bone. C. C. Simmons, Boston.—p. 629.

220: 651-690 (April 20) 1939

Malignant Melanomas: Clinical Study. E. M. Daland and J. A. Holmes, Boston.—p. 651.
Treatment of Chronic Pruritus Vulvae with Local Applications of Estrogen. A. Y. Kevorkian, Boston.—p. 661.
Outbreak of Infectious Diarrhea Among Newborn Infants. A. M. Kimberly, Worcester, Mass.—p. 664.
General Anesthesia. L. F. Sise, Boston.—p. 667.

Clinical Significance of Serum Phosphatase.—High concentrations of phosphatase, according to Looney, are found in ossifying cartilage, while only traces are found in the nonossifying type. In healing fractures no significant change in the serum levels of phosphatase occurs. In conditions affecting bone, the highest values are obtained when there is marked activity either in the formation of new bone or the destruction of old bone. Thus in osteitis deformans (Paget's disease), hyperparathyroidism (osteitis fibrosa cystica) and rickets the phosphatase levels may be from ten to twenty times above the normal values. However, in osteitis deformans the calcium and phosphorus values are normal, while in hyperparathyroidism the calcium is elevated and the phosphorus is low, and in rickets both calcium and phosphorus are low. The severity of the condition in all three diseases is indicated by the extent to which the serum phosphatase is elevated. The level of the serum phosphatase gives the most reliable single index for evaluating early and doubtful cases of rickets. In hyperparathyroidism the elevated values drop to normal after successful operation. Failure of the serum phosphatase to return to normal after operation is therefore an indication that some hyperfunctioning parathyroid tissue was not removed. In primary or metastatic osseous cancer the values are usually increased from two to five times the normal. Osteogenic sarcomas give rise to

increased phosphatase values if of the osteoblastic type, but not in the osteolytic type. Normal or but slightly elevated values are obtained in chondrosarcoma, giant cell tumor and multiple myeloma. The phosphatase values are normal in bone infections, senile osteoporosis, osteogenesis imperfecta and chronic osteitis. Although the serum phosphatase level does not give a clearcut differentiation in jaundice when the values are moderately increased, one can expect that jaundice in the presence of low values rules out the possibility of obstruction and that extremely high values favor this diagnosis. A fall in phosphatase values during the course of pulmonary tuberculosis indicates a grave prognosis, while an elevation is regarded as a favorable sign.

New Orleans Medical and Surgical Journal

91: 463-520 (March) 1939

Some Observations on Influence and Effects of Toxemias on Menstruation. L. A. LeDoux, New Orleans.—p. 463.
Burns, an Unsolved Problem. I. Cohn, New Orleans.—p. 465.
Care of Compound Injuries of Face. J. B. Brown, St. Louis.—p. 474.
Pitfalls in X-Ray Diagnosis of Intestinal Obstruction. L. A. Fortier and T. T. Gately, New Orleans.—p. 481.
Congenital Cystic Disease of Lungs: Two Case Reports, with Note on the Dynamic Phase. R. H. Bayley and D. E. Fader, New Orleans.—p. 483.
Pulmonary Atelectasis: Case Report. C. Jamison and R. G. Holcombe Jr., New Orleans.—p. 488.
Treatment of Headache with Theelin. R. S. Crichlow, New Orleans.—p. 490.
Of Psychoanalysis. J. K. Hall, Richmond, Va.—p. 491.

New York State Journal of Medicine, New York

39: 859-962 (May 1) 1939

*Rapid Bedside Test for Measuring Sedimentation Rate. E. Goldberger, New York.—p. 867.
Treatment of Tumors of Eyelids by Surgery. J. M. Wheeler, New York.—p. 870.
Social and Asocial Accompaniments of Intense Hormone Medication. E. Liss, New York.—p. 875.
Typhoid Osteomyelitis and Chondritis: Presentation of Two Cases in the Same Family. H. H. Ritter and S. J. Bochner, New York.—p. 877.
Laughlen Test for Syphilis. S. Price, New York.—p. 880.
Constitution and Situations. I. S. Wile, New York.—p. 884.
Compression Fracture of Spine: Treatment by Spinal Fusion. M. B. Howorth, New York.—p. 891.
Relationship of Industrial Medicine to Private Practice. C. D. Selby, Detroit.—p. 896.
Roentgen Therapy in Toxic Thyroid Disease. J. R. Freid and H. Goldberg, New York.—p. 900.
Physical Measures in Treatment of Neurologic Conditions. R. Kovács, New York.—p. 917.

Rapid Sedimentation Test.—Goldberger states that if drops of blood obtained by pricking the fingertips of different individuals are placed on inverted glass slides, the slides righted and the drops allowed to clot and dry spontaneously, the films, when examined macroscopically by holding them to the light, will show an interesting phenomenon. Some films will give the appearance of a uniform, coarse meshwork. In others, the detail will be fine and there will be a concentration of erythrocytes in the center. The character of the film depends on the degree to which the erythrocytes settle (sedimentation rate) before clotting occurs, coagulation time, degree of agglutination of the erythrocytes (rouleau formation) and rate of drying of the film. Under ordinary conditions the rapidity of drying is unimportant. The rate at which the erythrocytes settle is directly proportional to the degree of their rouleau formation. A slow rate will produce a film fine in detail and uniform in the distribution of the cells, whereas with a rapid rate the rouleaux will be large and the general appearance of the film that of a coarse meshwork. If the coagulation time is rapid compared to the sedimentation rate of the cells there will be a tendency for the cells to be drawn to the center of the film. A very slow coagulation time will merely cause a more uniform distribution of the cells. Fineness or coarseness of general detail, character of the meshwork (if present), presence or absence of central agglutination and presence or absence of a peripheral ring are the criteria for reading the films. With this in mind four groups may be described: + normal, fine detail, no meshwork and gradual transition from periphery to dark central agglutinated mass; + + moderately rapid, the detail being somewhat coarse but uniform throughout, meshwork not noticeable particularly and possibly the beginning of a central agglutinated mass; + + + rapid, coarse detail, the meshwork fine but easily observed and absence of a central agglutinated mass; + + + + very rapid, very coarse detail, definite meshwork and no central agglutinated mass. The test should not supersede regular methods of sedimentation rate, but in the office and at the bedside it is of distinct value. Not only is the test of diagnostic value, the author states, but the slides can be filed and the results checked week by week in cases such as coronary thrombosis, rheumatoid arthritis and salpingitis.

Public Health Reports, Washington, D. C.

54: 629-672 (April 21) 1939

Frequency of Dental Services Among 9,000 Families, Based on Nationwide Periodic Canvasses, 1928-1931. S. D. Collins.—p. 629.
Evolution of Disseminated Bacterial Infection in Guinea Pigs: Influence of Treatment with Insulin and Phlorhizin. M. P. Schultz and Edythe J. Rose.—p. 657.

Southwestern Medicine, El Paso, Texas

23: 107-138 (April) 1939

Looking Forward. C. S. Smith, Nogales, Ariz.—p. 107.
Addison's Disease: Report of Case Successfully Treated Through Three Critical Periods. M. M. Green, El Paso, Texas.—p. 110.
Collapse Therapy in Tuberculosis. V. S. Randolph, Phoenix, Ariz.—p. 114.
Effect of Phrenicectomy on Digestion. R. E. Lyons, Lordsburg, N. M.—p. 116.
Peroral Endoscopy as Aid in General Diagnosis and Treatment. M. P. Spearman and W. E. Vandevere, El Paso, Texas.—p. 118.
Retinal Glioma. O. W. Thoeny, Phoenix, Ariz.—p. 119.
*Effect and Treatment of Arizona Scorpion Stings. M. L. Kent and H. L. Stahnke, Mesa, Ariz.—p. 120.

Treatment of Scorpion Stings.—Kent and Stahnke state that at the Southside Hospital, between April 1930 and May 1937, seventy-five cases of scorpion stings were treated. Symptoms are invariably more pronounced in children. Stings by Centruroides sculpturatus, unless treated at once, are almost always fatal to infants less than 1 year of age. They are extremely dangerous to older children and may cause serious inconvenience to adults. A child stung will cry out with pain. Most generally there is little sign of the sting, in the form either of inflammation or of swelling. The victim soon becomes restless. The restlessness increases to a degree that the child becomes entirely unable to cooperate with attendants. It turns and frets; if placed on its back in bed it does not remain quiet an instant. Frequently it crawls across the bed and attempts to grab its mother or other attendant. The abdominal muscles may become rigid. There may be tonic contractions of the arms and legs. Drooling of saliva begins and the heart rate increases. The temperature may rise to 103 or 104 F. in a patient who will subsequently recover. Cyanosis gradually appears and respiration becomes increasingly difficult, causing a reaction not unlike that observed in a severe attack of bronchial asthma. There may be wheezing, especially on inspiration. Involuntary urination and defecation may occur. In fatal cases the same symptoms become so marked that the child apparently dies from exhaustion. In patients who recover, the acute symptoms subside in twelve hours or less. The foregoing symptoms may be encountered in the adult, but as a rule they are less severe. Numbness is usually experienced at the site of the sting. If one of the extremities has been stung, that member may become temporarily useless. Two cases of temporary blindness have been encountered. Some patients complain of malaise for many days following the sting. A tachycardia lasting two weeks developed in one patient. Morphine if used at all should be used with extreme caution. It has not been found effective in the usual dosage. Barbiturates are more effective and are less dangerous. Bromides in large doses are apparently of value. In cases characterized by severe pulmonary edema, atropine is indicated along with general supportive measures. Compresses of a fairly concentrated ammonium hydroxide solution have been found quite helpful if applied within a few minutes, but if they are applied as late as ten minutes after the sting no apparent benefit is attained. The author states that during the last eighteen months several of the more severe cases have been treated with scorpion serum with results that are encouraging. Symptoms were controlled more rapidly, and when the serum was used death has not occurred.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

British Journal of Ophthalmology, London

23: 225-288 (April) 1939

Foville's Syndrome: Record of Case. J. R. Mutch.—p. 225.
Projection Scotometer. F. A. Juler.—p. 239.
Theories on Formation of Aqueous Humor. J. D. Robertson.—p. 243.
Description of a Monster, Diprosopus Tetrophthalmus; with Notes on Histology of Median Eyes by J. Maude. I. Brodsky.—p. 250.
School Ophthalmic Service. A. Furniss.—p. 256.

British Medical Journal, London

1: 599-656 (March 25) 1939

Analeptics and Sympathomimetic Substances. J. H. Burn.—p. 599.
*Weil's Disease in Coal Miners. W. E. Rees.—p. 603.
*Weil's Disease in South Wales: Clinical Pathology. A. F. Sladden.—p. 605.
Early Diagnosis of Congenital Dislocation of the Hip. H. A. T. Fairbank.—p. 607.
*Pneumococcic Pneumonia, Complicating Pulmonary Tuberculosis, Treated with Sulfapyridine. J. H. Crawford.—p. 608.
Prognostic Significance of Ophthalmoscopic Findings in Cases of High Systolic Blood Pressure: Review of Eighty-Three Cases. R. U. Gillan.—p. 609.
Clinicopathologic Classification of Cancer of the Breast. R. W. Raven.—p. 611.

Weil's Disease in Coal Miners.—Six cases of Weil's disease in South Wales coal miners are reported by Rees, which he believes is the first record of this disease from that area. In each instance it was found that the men worked in wet places, and it was known that the pits concerned were infested with rats. In all six cases the clinical diagnosis was confirmed by positive serologic results. It is important to know that the organism flourishes only in fresh water. If the disease is becoming more common it seems possible that transmission by fresh water bathing may well become a matter for serious consideration. The possibility of spread of infection here is obvious. Again, as pointed out by Alston and Brown, workers exposed to infection may harbor what may be termed a "subclinical" form of the disease. In a series of apparently healthy sewer workers investigated it was found that 20 per cent showed positive serum agglutination reactions for Leptospira icterohaemorrhagiae. These writers suggest that prophylactic inoculation of workers exposed to the risk of infection would seem to be indicated. The disease does not always show itself in its well recognized characteristic form. Meningitis may be the presenting picture, as in the case described by Murgatroyd, who believes that it would be wise to consider a possible diagnosis of Weil's disease in many cases of so-called aseptic meningitis. In half of the cases there may be no jaundice. This being so, in all cases of pyrexia of unknown origin the possibility of spirochetal infection should be considered. In the author's present series of cases the symptoms were fairly typical. One observation of interest was that in three cases the blood pressure was definitely low. This seemed significant in view of the general complaint of weakness. All but one patient recovered, no serum, in effective dose, having been administered to any of the patients. However, to be effective serum must be given early and this series of patients were not seen before jaundice had appeared and the disease was well established.

Weil's Disease in South Wales.—Sladden states that, since the appearance and recognition of the cases of Weil's disease observed by Rees and three others in one locality, active measures have been taken by the colliery owners to rid the mines of rats. No further cases of Weil's disease have appeared in the mines concerned.

Pneumonia with Tuberculosis Treated with Sulfapyridine.—Crawford obtained no improvement from routine treatment of a case of pneumococcic pneumonia superimposed on a pulmonary tuberculous lesion until he gave the patient sulfapyridine on the sixth day of the patient's illness. The initial dosage (1 Gm. every four hours) was not high and as no toxic effects were observed higher doses could probably have been given with safety. The drug was discontinued after five days, which was apparently a little premature in this case, as slight relapse followed. It was easily controlled by further administration of sulfapyridine in the same dosage as before. There was no increase in activity of the tuberculosis as a result of the infection, and subsequent x-ray investigation of the chest revealed a definite improvement in the nature and extent of the lesion.

Irish Journal of Medical Science, Dublin

No. **159:** 97-144 (March) 1939

Prophylaxis in Practice. J. Mowbray.—p. 97.
Recent Advances in Therapy of Diseases of Muscle. E. L. Murphy.—p. 115.
Tuberculosis in Adolescents. Dorothy Price.—p. 124.
Sympathectomy in Treatment of Achalasia of Cardia: Case. H. S. Meade.—p. 130.

Medical Journal of Australia, Sydney

1: 371-410 (March 11) 1939

Some Aspects of Operations for Internal Derangements of Knee Joint. E. F. West.—p. 380.
"Pentothal Sodium" Anesthesia: Review, with Analysis of 333 Cases. S. V. Marshall.—p. 382.
Nonunion of Carpal Navicular Bone. F. H. M. Callow.—p. 391.

1: 411-450 (March 18) 1939

Control of Disordered Metabolism in Hypertrophic Pyloric Stenosis of Infancy. H. Williams.—p. 414.
Mycotic Flora of "Surfers' Foot" in Sydney. H. L. Kesteven.—p. 420.
Fractures of the Os Calcis. L. Teece.—p. 428.
Cause and Prevention of Blindness in Tasmania: Supplementary Report. J. B. Hamilton and W. D. Counsell.—p. 430.

1: 451-490 (March 25) 1939

Occurrence of the Rarer Demyelinating Diseases (Neuromyelitis Optica, Schilder's Encephalitis et Cetera) in South Australia. E. W. Hurst, C. T. C. de Crespigny and H. K. Fry.—p. 451.
Perforation of Stomach and Duodenum Due to Simple Ulcer and Carcinoma. M. P. Susman.—p. 456.
*Investigation of the Visscher-Bowman Test for Pregnancy. Vera I. Krieger.—p. 463.
Clinical Dietetics. A. R. Southwood.—p. 467.
Vascular Conditions of Muscular Exercise. N. D. Royle.—p. 472.

Visscher-Bowman Test for Pregnancy.—Krieger subjected the urine from 276 pregnant and nonpregnant women to the Visscher-Bowman test. The test was found exceedingly difficult to interpret, since it was frequently difficult to distinguish "powdery" and "flocculent" precipitates in such small volumes of liquid. The results obtained may be divided into the following types: (1) clear solution, (2) hazy solution, (3) slight, fine, dark brown precipitate, (4) heavy, fine, dark brown precipitate, (5) slight brown gelatinous precipitate, (6) dark brown gelatinous precipitate and (7) heavy, dark brown gelatinous precipitate. The last three types, the author states, are the only types in which a definite reaction could be specified, and under such restrictions there were 36 per cent positive reactions among fifty-eight nonpregnant women, 59 per cent positive results among ninety-one women pregnant no longer than three months, 67 per cent positive results among eighty-three women pregnant longer than three months and 55 per cent positive results among forty-four puerperal patients. The incidence of positive results in the pregnant groups is lower than reported by other workers and the number of positive results in the nonpregnant group is much higher. Five specimens of urine from male persons were examined. Two gave negative results, two gave slight precipitates, and a pronounced reaction was obtained with the fifth specimen. The Visscher-Bowman reaction is not an indication of the presence of the hormone of the anterior lobe of the pituitary in urine of pregnant women. The reaction may be due to (1) the presence of reducing carbohydrates, (2) marked concentrations of urinary pigment, with greater possibility of positive reaction in the presence of albumin and (3) the presence of other reducing substances in urine.

South African Medical Journal, Cape Town

13: 187-222 (March 25) 1939

Therapy and Paratherapy. R. D. G. P. Simons.—p. 189.
Predisposing Causes in Allergic Disease: Notes of a Personal Experience. C. D. Brink.—p. 199.
Hydatid Choleperitoneum. F. D. du T. van Zyl.—p. 203.
Value of Renal Function Tests. V. Vermooten.—p. 208.

Gynécologie et Obstétrique, Paris

39: 161-240 (March) 1939. Partial Index

Strabismus in Relation to Obstetrical Stigmas of Heredosyphilitic Origin. A. Fruhinsholz and J. Louyot.—p. 161.
Subumbilical Hysterotomy: Personal Statistics of Two Hundred Cases. L. Digonnet.—p. 169.
Sympathetic Nervous System and Contractibility of Uterus: Problem of Uterine Innervation. R. Mahon.—p. 177.
*Antepartum and Postpartum Azotemia. J. Chosson and P. Dor.—p. 189.
Comparative Study of Some Abortifacients: Their Effects on Pregnant Animals. A. Patoir, G. Patoir and H. Bédrine.—p. 201.

Antepartum and Postpartum Azotemia.—Chosson and Dor present the results of a clinical study of azotemia in twenty patients between the ages of 17 and 48, including primiparas and multiparas. The selection made at random was refined by retaining only those who were diagnostically proved to be free from defects of the kidneys and liver. The authors divide their study into two phases: (1) those (eight) in whom azotemia was observed before childbirth with the aid of hypobromite; (2) those (twelve) in whom azotemia was observed after childbirth, to which group those in group 1 were added. The observations indicated an average of 29 per cent, with extremes fluctuating between 20 and 45 per cent (the last a special case), are in accord with generally accepted conclusions and support the view that a lowered azotemia is found in pregnant women. In the second phase of their study, the authors test Estienny's alleged variations in postpuerperal azotemia indicating a high average of 43 per cent during two weeks after childbirth. Blood samples were taken by them on the second, fourth and sixth day post partum and before food ingestion. Their conclusions are that frequently a heightened postpuerperal azotemia occurs, with few individual differences. The apparent discrepancies between their and his observations are explained by the fact that they limited themselves to an observation of six days, while Estienny's extended over two weeks. In evaluating the results, the authors believe that one ought not to underestimate the fact that azotemia post partum is perceptibly close to that of normal physiologic conditions and that urea in the blood reduced during pregnancy because of hydremia tends naturally to normalize itself after childbirth.

Revue Neurologique, Paris

71: 257-368 (March) 1939

Electrophysiologic Study of Postural Regulation. P. Mollaret.—p. 257.
Induced Hyperglycemia as Test in Tumors of Hypophysis. Cossa, Augier and Rivoire.—p. 267.
*Peculiar Anatomoclinical Form of Chronic Alcoholism: Alcoholic Laminar Cortical Sclerosis. F. Morel.—p. 280.
Radiologic Symptom of Tumors of Posterior Fossa. J. Rossier.—p. 289.

Alcoholic Laminar Cortical Sclerosis.—Morel says that the neurogliar architecture may undergo profound transformations. For a number of years he has made systematic studies on the macroglia of the brains from patients with oligophrenia, with dementia praecox, with epilepsy, with dementia paralytica, with alcoholism, with cerebral arteriosclerosis and finally with senile degeneration. In all, the author studied more than 400 brains. The technic that he used for fixation and which he prefers to Cajal's gold chloride-mercuric chloride stain is a modification of the method of Globus. By means of this method he was able to obtain clear pictures of the macroglia in the majority of disorders enumerated. In this report he describes observations on four patients with chronic alcoholism. At the time of death their ages were 37, 51, 52 and 58 respectively. All had been greatly addicted to alcohol and presented signs of grave alcoholic gastritis. In their last years all had signs of alcoholic impregnation with prolonged atypical delirium tremens. Spasticity of the legs rendered walking difficult; there was severe tremor of the hands with mild carphology; also quivering of the face and stuttering. The Wassermann reaction of the blood as well as of the cerebrospinal fluid was negative in all four patients. The examination of the brains revealed that their weights were relatively high. There was subarachnoid edema but no fibrous leptomeningitis typical of dementia paralytica and no granular ependymitis. On the other hand, there was considerable cerebral arteriosclerosis. On microscopic examination, none of the four brains presented senile plaques, nor cellular changes of the Alzheimer type. There were no changes characteristic of dementia paralytica. All four cases presented proliferations of the neuroglia. These are not neurogliar islands or discontinued nests, which in places may have a laminar aspect but which in fact are pseudolaminar; on the contrary, these neurogliar proliferations form a continuous stratum limited to the third layer. Symmetric regions of the brain always show a remarkable similarity with respect to the extension and the intensity of this proliferation. To be sure, not all cerebral regions show it with the same clarity. It is especially pronounced in the frontal lobe, but in the ascending frontal convolution it is not as noticeable as in the other frontal convolutions. It is again more pronounced in the parietal region but toward the occipital lobe it tends to disappear. As regards the condition of the neuroglia in this third layer, the author says that the astrocytes in the third layer have numerous thickened vascular pedicles and they are stretched out. Thus it may be said that there is hyperplasia, hypertrophy and alteration of the astrocytes in the third layer. The microglia of the third layer likewise has undergone changes. Although in other parts of the cortex it is relatively fine and delicate, in the third layer it is coarse. The alterations presented by the nervous cells of the third layer are not particularly characteristic. The author suggests for the described cerebral modification the term "alcoholic laminar cortical sclerosis."

Sang, Paris

13: 225-351 (No. 3) 1939. Partial Index

Physiologic and Pharmacodynamic Studies on Spontaneous Hemostasis. J. Roskam.—p. 225.
"Agastric" Anemias. R. Leroux and E. Vermes.—p. 241.
*Hemopathies Caused by Benzene. F. Mignolet.—p. 268.

Hemopathies Caused by Benzene.—Mignolet was able to observe for many months a number of cases of benzene intoxication that occurred in a heliogravure workshop where benzene was used as a solvent for the ink. The benzene used is not chemically pure but is a mixture containing variable quantities of xylene and toluene and some impurities. The solvent that caused the accidents described here contained 80 per cent of benzene and nearly 20 per cent of toluene. The onset of the poisoning is not characteristic. The patients complain first of disorders of a nervous type, such as vertigo, headaches and abnormal excitation. Soon anorexia and somnolence develop, then asthenia and fatigability and often muscular cramps. Frequently the patients appear emaciated and pale. Cardiac involvement is indicated by rapid pulse, palpitations and arterial hypotension; respiratory symptoms are dryness of the throat, cough, dyspnea, suffocation and sensations of thoracic constriction; disorders of the digestive tract are anorexia, hypoacidity, nausea, vomiting, constipation and hepatic congestion; hemorrhagic symptoms are petechiae, ecchymoses, epistaxis, gingival bleeding, hemoptysis and menorrhagia. Moreover, many patients have attacks of fever, particularly at the time of relapse. The author observed twenty-six cases of benzene intoxication; fourteen were grave and necessitated prolonged inactivity (eighteen months and more). One patient, a man aged 29, died with symptoms of severe anemia and agranulocytosis in spite of repeated blood transfusions. In the second part of this report, the author shows that benzene is a poison of the blood, describing its effects on the various hematic elements. Regarding the therapy, he says that he obtained favorable results with the injection of liver extracts. Extracts administered by mouth only improved the appetite but were without action on the hemogram. However, the transfusion of citrated blood proved to be the most effective of all therapeutic procedures. Ephedrine and strychnine proved helpful against the asthenia. The author thinks that, in order to prevent poisoning with benzene, workers who have to use it must be carefully examined. Persons with cardiac, anemic, hepatic, renal and thoracic disorders or with a predisposition for them should be rigidly excluded from occupations that necessitate contact with benzene. Persons who do work with the substance should be examined at regular intervals (every two or three months), the examination to include a complete hemogram. Strict hygienic measures should be enforced in the shop (washing of hands, wearing of masks, proper ventilation and so on). In the conclusion, the author emphasizes that thrombopenia and prolongation of the time of coagulation are signs of alarm, but granulopenia is already a sign of intoxication. The anemias of benzene intoxications are usually hyperchromic aplastic anemias.

Schweizerische medizinische Wochenschrift, Basel

69: 261-284 (March 25) 1939

Chronic Gastric Ulcer and Its Pathogenesis. L. Aschoff.—p. 261.
Uniovular Twins with Multiple Sclerosis. R. Isenschmid and M. Olloz. —p. 267.
Familial Occurrence of Besnier-Boeck's Disease. M. Dressler.—p. 269.
*Scarlet Fever Streptococci. W. Wyler.—p. 272.
Two Observations of Posterior Hernia of an Intervertebral Disk. E. Jéquier and J. Rossier.—p. 273.

Scarlet Fever Streptococci.—Wyler says that although it seems definitely established that streptococci play a part in the pathogenesis of scarlet fever, it is as yet not certain whether scarlet fever is caused by a special type of streptococcus or whether it represents an especial reaction of the organism to the streptococcic infection. He reports a case in which it proved impossible to differentiate between streptococcic sepsis and scarlet fever. A boy aged 10 sustained lacerations and contusions below the left knee when he fell into a pit filled with liquid manure. In spite of excision of the wound and of the administration of tetanus serum, fever and symptoms developed on the basis of which meningitis and tetanus were thought of. Later, the diagnosis wavered between tetanus and sepsis, but tetanus could be excluded on the basis of the blood picture. There was no typical scarlet fever, no redness of the throat, no angina and no exanthem. A blood transfusion that was given to overcome a serious circulatory impairment effected a rapid improvement in the circulation and it was followed by the appearance of the circumoral pallor and the strawberry tongue; that is, by symptoms typical of scarlet fever. The questions raised by this case are: 1. Was the causal organism in this case a specific scarlatinal streptococcus; that is, did the boy have a fulminant traumatic scarlatina? 2. Was the reactivity of the organism such that it reacted to the streptococcus in the wound with scarlet fever? 3. Was the disorder simply a streptococcic sepsis which was modified by the transfusion into a scarlatina-like process? These questions are undecided, but the author is inclined to accept the latter version, namely that a severe septic process, caused by streptococci, took on a scarlatina-like course after a blood transfusion.

Dermosifilografo, Turin

14: 141-200 (March) 1939. Partial Index

*Urethritis from Enterococcus: Clinical and Bacteriologic Study. G. Rivelloni and A. Spanedda.—p. 141.
Induratio Penis Plastica and Nicolas-Favre's Disease. A. Midana.—p. 163.
Etiology of Annular Granuloma and Case of Rare Location. U. Cavallucci.—p. 173.
Value of Chediak Test in Diagnosis of Syphilis. L. Gabriele.—p. 192.

Urethritis from Enterococcus.—Rivelloni and Spanedda point out the importance of nongonococcic urethritis. They made observations on a group of fifty-six patients (forty-eight men and eight women) who were suffering from enterococcic urethritis. The condition may be either primary, which follows sexual intercourse, or secondary, which follows a controlled gonococcic infection. In either form the period of incubation lasts for ten or twelve days, the symptoms are mild and the urethral secretion is scanty, mucous, thick and yellow. The urogenital apparatus is not involved. In urethritis in men the only urethroscopic observation consists in the presence of moderate diffuse hyperemia at the anterior urethra, which is milder in the primary form than in the secondary form. The posterior urethra in men and the female urethra do not show urethroscopic changes. The bacteria isolated from the urethral secretions belong to type C of Koch's bacteria and dissociate into the S and R phases. The infection does not heal spontaneously. The authors reproduced, experimentally, enterococcic urethritis in various groups of volunteers. They succeeded by injecting 3 cc. of a pure culture of Enterococcus in the normal urethra and also by making passes of the experimental infection. In women the condition, either clinical or experimental, develops in association with enterococcic cervicitis. The authors found that Enterococcus in vitro is resistant to sulfanilamide preparations and that the latter preparations, when they are administered alone, whether by mouth, in intramuscular injections or in local applications, fail to control the clinical and experimental infections. Autovaccines administered to the patients also fail. The author obtained satisfactory results from a combined treatment which consisted in administration of sulfanilamide by mouth, local instillations of a 0.25 or 1 per cent silver nitrate solution every day, for the duration of three or five minutes and lavages, every other day also, with a 1:5,000 potassium permanganate solution or a 0.1:1,000 mercury oxycyanide solution. Patients in poor general condition were given preparations of arsenic or phosphorus. The treatment must be given over a long period of time in order to prevent possible recurrences.

Oto-Rino-Laringologia Italiana, Bologna

9: 1-104 (Jan.) 1939. Partial Index

*Cancer and Tuberculosis of Larynx. G. Rossi.—p. 1.
Otomastoiditis and Mastoidectomy in Infants. L. Padoin.—p. 33.
Action of Basal Anesthesia with Barbital Preparations on Vasomotor Reflexes. R. Abbate.—p. 65.

Cancer and Tuberculosis of Larynx.—In a group of seventy patients suffering from primary cancer of the larynx and seen at the Clinica Oto-Rino-Laringologica of the University of Bologna, Rossi observed four who had cancer of the larynx associated with laryngeal tuberculosis. The four patients ranged in age from 45 to 57. Only one patient was under 30. The diagnosis of the diseases was made by microscopic study of the tissues, which were removed by biopsy, and in two cases also by study of the larynx, which was removed by laryngectomy. Metastases were not present in any of the cases. According to the author there is no antagonism between cancer and tuberculosis in the same organ. The larynx is a structure which may be the seat of either tuberculosis or cancer in the presence of or preceding the other disease. The most frequent forms of laryngeal cancer in tuberculosis are (1) cancer of the normal larynx complicating pulmonary tuberculosis, (2) cancer of the tuberculous larynx and (3) primary laryngeal cancer with secondary development of laryngeal tuberculosis. A clinical diagnosis is difficult. The diagnosis is made by biopsy. When the patients are in good general condition and the disease is in its early phase of development a laryngectomy may give satisfactory results. However, the author calls attention to the fact that either tuberculosis or cancer of the larynx alone is grave. Consequently the association of the two conditions is still more grave. Moreover the evolution of the two conditions in association will depend on several factors, such as for instance the individual resistances, the phase of evolution and the more or less malignant type of the disease and the administration of early treatment.

Rivista di Clinica Medica, Florence

39: 623-666 (Oct. 30-Nov. 15) 1938. Partial Index

*Variations of Chloremia from Administration of Ascorbic Acid. C. Pegoraro and G. Comi.—p. 623.
Participation of Nervous System in Diseases of Reticulo-Endothelial System. L. Greco.—p. 641.

Chloremia from Ascorbic Acid.—Pegoraro and Comi made determinations of chloremia in a group of thirty-six persons including normal persons and patients who were suffering from different diseases. The determinations were made on fasting persons before and after the administration of an intravenous injection of 0.5 Gm. of ascorbic acid. They were performed at intervals of one hour. The authors found that chloremia diminishes after the administration of ascorbic acid. The lowest figures of the curve of chloremia correspond to the third hour in the course of the test, after which chloremia slowly returns to high figures, which however are lower than those which existed before administration of the acid. If the test is repeated one week later during which the patients receive daily intravenous injections of 0.5 Gm. of ascorbic acid, the figures of chloremia during fasting and before administration of the acid on the day are lower than those which were observed in persons in the same condition in the test previously made. The authors carried on determinations of diuresis and of the elimination of chlorides through the urine in a group of eight patients who were suffering from different diseases. The determinations were made on the total amount of urine which was eliminated in the course of three days before and after the administration of ascorbic acid in daily doses of 0.5 Gm. The authors found that both diuresis and the elimination of chlorides through the urine increase from the treatment. Therefore they conclude that the administration of ascorbic acid in doses of 0.5 Gm. induces diminution of chloremia and increase of diuresis and chloruria.

Chirurg, Berlin

11: 217-256 (April 1) 1939

Hormonal Therapy of the Prostate. O. Orth and O. Hasslocher.—p. 217.
*Bilateral Carotid Tumor: Case. G. Marangos.—p. 222.
Cranial Injury and Aphasia of Polyglotts. O. Winterstein and E. J. Meier.—p. 229.
Heller's Extension Apparatus. Matthaes.—p. 232.
Treatment of Sciatica with Periarticular Intervertebral Procaine Hydrochloride Infiltration. S. Teneff.—p. 237.

Bilateral Carotid Tumors.—The relatively recent knowledge of tumors of the carotid gland, according to Marangos, dates from their description by Marchand and Paltauf. The rarity of the lesion may be judged from the fact that MacCarthy and Bevan were able to collect from the literature up to 1929 not more than 131 cases. Rankin and Wellbrock collected 196 cases in world literature up to 1932, while sixteen more cases are to be found in recent contributions. Bilateral occurrence of the tumor was reported twice, once by Rankin and Wellbrock and once by Lund. The author reports a successful operative removal by Makkas of bilateral carotid tumors in a girl aged 23 at the Red Cross Hospital in Athens. The tumor on the right side was noticed by the patient five months after the removal of the tumor on the left side and was operated on three months later. Both tumors were removed without damaging or ligating the common carotid artery, either of its two main branches or the vagus nerve. Both tumors presented on a microscopic examination identical structure, that of a paraganglioma or struma of the carotid gland. The paragangliomas represent hypertrophy of the cellular structure of the carotid. They develop at the site of bifurcation of the common carotid artery, grow slowly and seldom undergo malignant transformation. The far more rarely occurring neurofibromas develop from the nervous elements of the carotid plexus and are, as a rule, malignant. The surgical removal of the tumor, while theoretically most desirable, is hazardous and technically difficult. It carries with it the dangers of postoperative bleeding, paralysis of the hypoglossus nerve, Horner's syndrome and syncope or sudden death due to the irritation of the carotid plexus. In a considerable proportion of the cases there arises the necessity of ligating the common carotid artery. The latter procedure is associated with an immediate mortality of 32 per cent, according to Hartmann. The author is of the opinion that removal of a small tumor without ligation of the common carotid artery is possible in not more than one third of the cases and that in this group the mortality is about 5 per cent. The postoperative complications following ligation of the artery are hemiplegia and paralysis of the vagus, the sympathetic and the hypoglossus. Roentgen therapy is not successful because of the lack of radiosensitivity on the part of the mature cells of the paraganglioma. Barbier and Hartmann suggest exposure of the tumor and an immediate biopsy. If the tumor is benign, as much of it as is possible is removed, and the remaining tissue is subjected to later roentgen irradiation. Only in the case of a malignant growth do they feel that ligation of the common carotid artery is justified.

Klinische Wochenschrift, Berlin

18: 337-368 (March 11) 1939. Partial Index

Modifications of Vitamin C, of Inhibin and Lipase in Raw and Heated Human Milk. W. Catel.—p. 342.
Effect of Nicotinic Acid on Different Anemias. D. Ackermann, H. G. Fuchs and E. Brandes.—p. 348.
*Regulation of the Calcium Content of the Blood. F. Linneweh.—p. 350.
Pancreatitis in Infectious Diseases. M. Gülzow.—p. 353.
Micro-Analytic Demonstration of Presence of Lead in Fluids of the Body. G. Straube and H. Beck.—p. 356.

Calcium Content of Blood.—Linneweh reports his observations of hypocalcemia secondary to hypalbuminosis and indicates a new regulatory blood mechanism. The diseases studied are etiologically unrelated, show no spasmophilia (except for a sporadic case) and are characterized by an albumin deficiency with a tendency to edema and by hypocalcemia. Clinical experiences, the author says, clearly prove that certain diseases accompanied with tetany are caused by a calcium deficiency but have yielded only meager information on the regulatory process of the calcium content. By means of dialysis and ultrafiltration, the total calcium content of the blood can be determined in its component parts: diffusible (the larger part positive, the smaller electrically neutral) and nondiffusible. Normally, the diffusible portion is said to amount to from 5 to 6 mg. per hundred cubic centimeters. This proportion is lowered when the parathyroid glands are removed. Reduction is also observable in cases of pure tetanus. According to the author, probably other regulatory mechanisms of a hormonic and nervous nature besides the parathyroid glands exist and affect the total calcium content, but their effects do not seem to be important. Hypocalcemia is found in other diseases that do not show tetanus and spasmophilia, but there is still much doubt as to what extent the changes in the calcium content are really characteristic of these diseases and what the true cause is. In only a few cases were the diffusible and nondiffusible portions of the reduced calcium content studied separately or was a satisfactory explanation of the calcium reduction given. Among the diseases studied by the author showing hypalbuminosis are war edema, pancreas deficiency, nephrosis, pericarditis and ascites. In all these diseases a regular relationship is observable between the calcium level and the albumin level. Because of the practical absence of tetany, the author does not regard dysfunction of the parathyroid glands as causative of hypocalcemia secondary to hypalbuminosis but of physiochemical relationships, a portion of the calcium being combined with and dependent on albumin in the blood. It may be accepted as scientifically demonstrated that the nondiffusible portion of the calcium is dependent on the albumin. Often the percentages obtained by ultrafiltration, he says, for the dependency of calcium on albumin were found to be higher than those obtained by dialysis. The clinically ascertained parallelism of fluctuation between the calcium content and the albumin content indicates a close connection between the two substances. This connection is so close that not only the ultrafiltrable but also the nonultrafiltrable portion of the calcium shows a decrease when the albumin content decreases. The author, therefore, regards the designation of diseases as "hypocalcemias secondary to albuminosis" as terminologically justified. He sees a twofold value in recognizing this class of disease: 1. One need not at once infer increased spasmophilia from decreased calcium content. 2. The reduction of the calcium reserve that is dependent on the albumin content limits the efficiency of the regulatory mechanism. The appropriate therapy is to restore the normal calcium reserve. Removal of hypalbuminosis increases the ability of the calcium to combine. Normalizing of the diffusible and nondiffusible portions of the calcium is best attained by a diet rich in albumin.

18: 401-452 (March 25) 1939. Partial Index

*Vitamin C Content of Human Brain with Special Reference to Vegetative Centers. F. Diehl and H. Neumann.—p. 418.
Modifications in Cholesterol Content of the Blood After Sea and Sun Baths. H. Curschmann.—p. 434.
Changes in Wavelength of Electrocardiogram Accompanying Changes in Dilatation of the Heart. W. Weitz and H. Warnecke.—p. 441.
Heparin in the Blood. W. Grunké.—p. 443.
A New Vasodilator. H. Zothe.—p. 443.

Vitamin C Content of Human Brain.—Diehl and Neumann report the use of methylene blue (as applied by Bonsignore and Martini) to determine the vitamin C content of the various portions of the brain in nineteen adults between the ages of 21 and 84 and one infant aged 7 weeks. Clinical research emphasized the difference between the vegetative and nonvegetative brain centers. The anatomic procedure is indicated for the portions of the brain studied. The greatest vitamin C content was found in the tuber cinereum, medulla oblongata and hypophysis in the order given, the lowest in the cerebellum, corpus callosum and cerebrum, ascorbic acid being represented in the extremes of 1.2 mg. and 30.5 mg. per hundred cubic centimeters in the adult brains and of 48 mg. per hundred cubic centimeters in the hypophysis of the infant brain. The authors suggest that the difference in vitamin C content between the high and low group is due to the difference in vegetative centers, Bodechtel's investigations having already established the vegetative significance of the brain portions rich in vitamin C. On the other hand, according to the authors, the brain portions with lowest content have clearly little to do with vegetative functions. Results relative to the hypophysis invite the conjecture that the hypophysis of healthy persons contains the highest proportion of vitamin C but that, whenever a deficiency of this vitamin occurs in a person, the hypophysis suffers a much earlier and more

incisive curtailment of its functions. The interpretation of the results follows the conclusions of Tonutti that a high vitamin C content of an organ is indicative not of a process of "storing" vitamin energy but of the immediate active demands made by the system on it. The more active an organ is, the more vitamin C it contains. The portions of the brain that are the last to cease functioning are connected with the vegetative centers and as the most active are richly supplied with vitamin C. This interpretation, the authors believe, also accounts for the fact that the brain portions intermediate between the high and low groups show so great a fluctuation. Manifestly, shortly before life becomes extinct and varying according to the person and the pathophysiologic picture, some of the intermediate brain portions flicker into a final intensity of function at one time or another. On the other hand, the lowest of these portions in the authors' rating scale, the cerebrum, reduces its functioning to a minimum long before death. The conclusions of others pertaining to the relations existing between age level and vitamin C content have been confirmed in this investigation.

Medizinische Klinik, Berlin

35: 337-368 (March 17) 1939. Partial Index

Treatment of Uterine Retroflexion. F. A. Wahl.—p. 337.
Therapy of Malignant Ovarian Tumors. W. Benthin.—p. 339.
Pregnancy and Cholelithiasis. H. Rupp.—p. 341.
Use of Roentgen Rays in Obstetrics and Gynecology. P. Werner.—p. 344.
*Value of Prophylactic Administration of Prontosil in Manual Detachment of Placenta. A. Pohl.—p. 346.

Prontosil Prophylactically in Manual Detachment of Placenta.—A review of the literature on the prophylactic administration of sulfanilamide preparations in septic complications of the puerperium discloses favorable results, but Pohl admits that it is unnecessary to administer sulfanilamide to every puerperal woman. Manual detachment of the placenta, which is one of the most dangerous obstetric operations, justifies the prophylactic use of sulfanilamide. The prophylactic treatment employed by the author consisted in the intragluteal administration of 0.25 Gm. of prontosil. This prophylaxis was used in forty-six cases of manual detachment of the placenta. Comparing the cases of manual detachment of the placenta in which prontosil prophylaxis was used with those of previous years in which this form of prophylaxis was not used, it was found that the women who were given this treatment could be discharged from the clinic as early as after spontaneous delivery except in the cases in which severe anemia necessitated a longer stay. None of the thirty-six women in whom manual detachment was the only operation developed endometritis or thrombophlebitis when prontosil prophylaxis was employed, whereas in the same number of cases in which prontosil prophylaxis was not employed each of these complications developed twice. In the remaining ten of the aforementioned forty-six cases, the manual detachment was performed following other vaginal operations. A comparison with the same type of cases in which prontosil prophylaxis was not employed again proved the efficacy of the prontosil prophylaxis. In general, it can be said that manual detachment of the placenta as the only operation is less dangerous than when it is combined with other operations. The author thinks that all puerperal women who are threatened with septic infections should be given immediately an intragluteal injection of 0.25 Gm. of prontosil. Following this, they should be given three times daily, for four days, one tablet of prontosil. The author thinks that this prophylaxis will reduce not only the mortality but also the puerperal diseases likely to result in sterility.

Zeitschrift für Immunitätsforschung, Jena

95: 169-344 (March 10) 1939. Partial Index

Modification of Phagocytosis by Bacterial Capsule and Bacterial Polysaccharides. S. Mielnik-Kosmiderski.—p. 203.
Comparative Investigations on Local Anaphylaxis of Gastrointestinal Tract. Tao Shen Kiang.—p. 227.
Aspects of Some Types of Hemolytic Streptococci of Group A. R. Haas.—p. 238.
*Determination of Blood Group as Sedimentation Reaction. F. Sander and Meta Sander.—p. 268.

Blood Group Sedimentation Reaction.—The blood group sedimentation reaction described by the Sanders has the aim to measure differences in the intensity and in the time factor of the isohemagglutination better than was possible with the former methods. The authors point out that it has been investigated repeatedly whether connections exist between the sedimentation speed of the erythrocytes and the blood group to which the erythrocytes belong. With the ordinary technic of blood sedimentation, the authors were unable to detect group specific differences in the sedimentation. However, the conditions become quite different when the erythrocytes are brought in contact with serums that are antagonistic to the group; that is, when the erythrocytes of groups A and AB are combined with anti A (beta) or O (alpha, beta) serum or when B or AB erythrocytes are combined with B (alpha) or O (alpha, beta) serums. In these cases, the sedimentation speed is enormously increased; within a few minutes, the erythrocytes may drop from 200 mm. (Westergren) to 10 per cent of the height of the column, a drop of 180 mm. This rapid sedimentation is preceded by a more or less coarse conglobation of the erythrocytes, which is similar to that observed in the determination of the blood groups. This conglobation of erythrocytes is the result of an agglutinin fixation by the erythrocytic receptors. The authors suggest the following method for the determination of the blood groups by means of sedimentation: Several cubic centimeters of venous blood is withdrawn and the serum is separated from the erythrocytes by centrifugation. Then 0.6 cc. of the serum to be examined is placed into each of two small test tubes and is mixed with an equal amount, that is, 0.6 cc. each of a suspension of test erythrocytes, of A or B erythrocytes in physiologic solution of sodium chloride (dilution 1:10), and this mixture is immediately drawn up into a Westergren pipet. Then, frequently after a few seconds, the strong conglobation of erythrocytes is observable and this is followed by a rapid sedimentation. The results are then read in the manner customary for the blood group test. That is, if sedimentation has taken place in both serum specimens, with A as well as with B test erythrocytes, it is an O (alpha, beta) serum; if sedimentation is produced only with A test erythrocytes, it is in the first case a B (alpha) serum and in the second case an A (beta) serum, and if there is no sedimentation at all the serum in question is of the AB type. The authors further describe a number of factors that may eventually be of influence on the course of the reaction and direct attention to two entirely different types of sedimentation, the rapid and the slow type. Finally they suggest the possibility of an "analysis" of the sedimentation of the erythrocytes by means of the sedimentation method.

Zeitschrift f. menschliche Vererbungslehre, Berlin

23: 1-168 (March 6) 1939. Partial Index

Studies on Family Groups with Harelip and Clefts of Hard and Soft Palate. J. Mengele.—p. 17.
Anomalies and Complexes of Anomalies in Region of First Pharyngeal Arch. H. Günther.—p. 43.
*Hereditary Origin of Thrombo-Angiitis Obliterans: Contribution to Problem of Heredity in Rheumatism. O. Reichert.—p. 53.
Formation of Human Hand as Expression of Habitus: Anatomic-Photographic Serial Investigations on Constitutional Pathology. Ilse Zenneck.—p. 67.
Chondrodystrophy and Acanthosis Nigricans: Question of Personality of Persons with Chondrodystrophia and Degree of Manifestation of Chondrodystrophic Characteristics. H. Lange-Cosack.—p. 94.
Involvement of Hereditary Factors in Pathogenesis of Eclampsia. W. Bickenbach and F. Kröning.—p. 113.

Heredity of Thrombo-Angiitis Obliterans.—On the basis of the assumption that the mechanisms of the pathogenesis of rheumatism and of thrombo-angiitis obliterans are related, Reichert decided to investigate whether in families of patients with thrombo-angiitis obliterans there is an increased incidence of rheumatic diseases. Moreover, since thrombo-angiitis obliterans is a vascular disease with a tendency to the formation of thrombi, he gave his attention to the occurrence of other vascular disorders such as atherosclerosis, apoplexy, thrombosis, embolism and infarct. Starting with patients who had thrombo-angiitis obliterans, he made studies on three extensive family groups. He noticed a high incidence of diseases of the rheumatic type in general and of articular rheumatism in particular. He stresses that the observations on these family groups provided new proofs for the hereditary origin of the hyperergic mode of reaction and of rheumatism. Observations on two of the families indicated that, besides the inferiority of the connective tissue system, the susceptibility of the vascular apparatus is a decisive factor in the pathogenesis.

Orvosi Hetilap, Budapest

83: 329-356 (April 8) 1939. Partial Index

Experiments with Synthetic Estrogen. C. Fátyol.—p. 336.
Common Factor in Treatment of Schizophrenia. B. Mezei.—p. 339.
Delirium Due to Pellagra: Case. I. Kulcsár.—p. 341.
*Narrowing of Arteries of Lung Due to Shale-like Incrustation of the Lung Hilus. F. Orsós.—p. 345.

Narrowing of the Lung Arteries Due to Incrustation of Lung Hilus.—Two cases of interest in forensic medicine are reported by Orsós in which circulatory trouble was found to be the sole cause of death, leading to degeneration of an overburdened right heart. Both patients were over 60 years old at the time of death. Careful observation of the lungs revealed an obstruction at the lung hilus at the secondary branches of the lung arteries or somewhat below. The obstruction, in the shape of a funnel or hourglass, was caused by the shale-like incrustation of the enlarged hilus lymph nodes and their surroundings. As a result of the incrustation, the interstitial tissue of the hilus, together with the lymph nodes, changed into a hard tissue-plaster, in which the blood vessels were embedded. Microscopic examination of one of the cases revealed that the wall of the narrowed secondary branch of the lung artery was of varying thickness. It was even missing on one side, granulation tissue taking its place, narrowing in its turn the already narrowed passage.

Vestnik Khirurgii, Leningrad

57: 1-230 (Jan.) 1939. Partial Index

Fortieth Anniversary of Discovery of Radium. N. N. Petrov.—p. 5.
Treatment of Cancer of Mouth and Its Late Results. A. A. Epshteyn.—p. 21.
Trauma Caused by Teeth as Etiologic Factor in Leukoplakia of Oral Mucosa and Tongue. A. S. Olshanetskiy.—p. 40.
*Tumors of Upper and Lower Lips Treated at the Oncologic Institute of Leningrad in Last Ten Years. A. P. Shanin.—p. 43.
Malignant Tumors of Lateral Regions of the Neck. N. D. Perumova.—p. 63.
Symptomatology and Pathology of Carotid Tumors. M. M. Lyakhovitskiy.—p. 78.
*So-Called Metastasizing Adenomas. S. A. Kholdin.—p. 153.

Tumors of Lips.—According to Shanin, fifty-six cases of tumors of the upper lip and 681 of the lower lip were treated at the Oncologic Institute of Leningrad between 1926 and 1936. Tumors of the upper lip were encountered more frequently in women than in men. About one third of the tumors of the upper lip were either benign or precancerous lesions. The greater variation in their histologic structure, as compared with that of the tumors of the lower lip, is to be explained on the basis of a derivation from a greater number of embryonic elements. The duration of the lesion at the time of admission was essentially the same for the second five year period as for the first. The author advocates radical removal of the precancerous lesion extending 0.5 cm. into healthy tissue. In the surgical removal of tumors of the upper and the lower lips inclusion of 1 cm. of healthy tissue for the early lesions and of 1.5 cm. for the more advanced lesions is advocated. The follow-up cases thus treated showed 80 per cent of cures for a considerable time. Experience with irradiation showed the necessity of increasing the dosage to 1.5 millicuries for each square centimeter of irradiated surface when radium implantation was used, and to 2 or 3 millicuries for each square centimeter of irradiated surface when radium was applied at a distance of from 1 to 2 cm. The dose was likewise increased to 3,000 or 4,000 roentgens when the fractional method was applied. The surgical removal of tumors of both lips is applicable to cases in which the operation can be easily carried out and in which it will not be followed by a disfiguring scar. Electrosurgery is indicated for lesions developing on the basis of leukoplasia or leukokeratosis. Recurrences involving complicated plastic procedures for their removal were treated instead with radiation. Radium implantation therapy resulted in 70 per cent of cures and radium application in 61 per cent. The difference in all probability was due to the fact that the implantation method was applied to the earlier cases. The implantation method gave best results in tumors in the second or third stage, while radium at a distance gave best results with tumors in the first stage. Radium implantation proved to be the best method in recurrences. Regional metastases were treated by operative removal in 266 cases and by roentgen therapy in fifty-two. Preoperative roentgen irradiation increased the effectiveness of the operative removal. The operation for regional metastases involved the removal of all submaxillary connective tissue along with the salivary glands and lymph nodes from both sides. Complications of inflammatory nature exerted an unfavorable influence on the malignant process.

So-Called Metastasizing Adenomas.—The formulation of a satisfactory classification of tumors of the thyroid, according to Kholdin, is difficult because of a number of tumors of a transitory type and because of lack of correspondence in some cases between the microscopic structure of the neoplasm and its clinical course. To this group belong the rather infrequent but interesting variety of so-called metastasizing adenoma first described by Cohnheim in 1876. Simpson has collected seventy-seven cases up to 1926. Only those adenomas the microscopic structure of which as well as the microscopic structure of their metastases do not contain carcinoma cells are to be included in this group. The microscopic structure of the metastatic nodules resembles almost entirely those of the primary tumor. The predominating type is one made up of small follicles lined with high cuboidal or cylindric epithelium and containing colloid. Among the microscopic characteristics which differentiate this tumor from ordinary benign adenomatous colloid goiter, the author stresses the invasion of the capsule of the adenoma by the epithelial elements and more particularly their invasion of the blood vessels. The author suggests that the term "angiophilic" more accurately describes this adenoma than the term "metastasizing" or "malignant." These tumors, in the opinion of the author, occupy an intermediary position between benign and malignant neoplasms of the thyroid but are to be considered, because of the tendency to invasion of the blood vessels, as potentially malignant. The author feels that all new growths of the thyroid not associated with sexual maturation or endocrine disturbances should be removed and examined microscopically. Invasion of the blood vessels may be observed by the naked eye in the course of a thyroidectomy. Such vessels should be ligated and resected; if necessary the internal jugular vein should be similarly treated.

Vrachebnoe Delo, Kharkov

20: 801-1028 (No. 11-12). 1938. Partial Index

Problems of Experimental Medicine in Combating Premature Senescence. A. A. Bogomolets.—p. 809.
*Therapeutic Transplantation of Tissues. V. P. Filatov.—p. 813.
Reflex Trophic Disturbances Following Injury to Arterial Trunks. V. N. Shamov.—p. 821.
*Pulmonary Cancer and Tuberculosis. I. I. Faynshmidt and M. Ya. Karliner.—p. 827.
Stages of Croupous Pneumonia. L. F. Dmitrenko.—p. 833.
Ahemoblastosis. A. L. Myasnikov.—p. 837.

Transplantation of Tissue for Therapeutic Purposes.—According to Filatov, partial superficial corneal transplants taken from a cadaver and conserved for from two to seven days at a temperature of from 2 to 4 C. gave better results than when fresh corneal tissue was used. Excellent results were obtained in the last two years in seventeen cases in which the original corneal transplant began to turn opaque. Partial corneal transplants from a cadaver placed at the margin of the opaque transplant rendered it once more translucent. The author treated a variety of inflammatory processes of the cornea with this method and obtained striking therapeutic effects. In eight cases of parenchymatous keratitis of syphilitic origin, the process was arrested in from eight to ten days and the regressive period was considerably shortened. Striking results were likewise obtained in cases of herpetic keratitis, tuberculous keratitis, keratoconus, trachomatous pannus, tuberculous choroiditis and pigmented choroiditis. The method was applied in cases of lupus vulgaris of the face, in tuberculous ulcers, burn scars, scleroderma, psoriasis and duodenal ulcers. In cases other than those involving the eye, the author used various tissues removed from a cadaver, such as skin, labial mucous membrane or blood vessel wall. These were kept for from five to seven days at a temperature of from 2 to 4 C. The

therapeutic effect manifested itself either in rendering the tissue translucent and elastic (cornea), in absorbing a scar, or in stimulating regenerative processes (ulcers). This effect was obtained with autoplastic as well as with homoplastic transplants. The author does not possess as yet sufficient material to determine the relative value of the autotransplant. He attempts to explain the therapeutic effect of skin taken from cadavers and kept refrigerated for several days by assuming that the tissue thus kept is still alive but that in the early stages of its mortification it contains certain products of decomposition capable of acting as catalyzers. They are probably related to the stimulating substances in traumatized tissues, as pointed out by Haberland, and to the "necrohormones" of Caspari appearing during the early stages of decomposition of dead tissue.

Pulmonary Cancer and Tuberculosis.—Faynshmidt and Karliner personally observed 115 cases of primary bronchogenic carcinoma in an attempt to establish the possible etiologic relationship of pulmonary tuberculosis to pulmonary cancer, the effect of one on the other and their differential diagnosis. Hunter's as well as Rokitansky's theory of antagonism of the two processes and their incompatibility in the same organism is refuted by the more recent observations, according to which the coexistence of the two was observed in from 2 to 30 per cent. Most observers emphasize that it is the inactive, fibrous type that is seen in these cases. In the authors' material the coexistence of primary bronchial carcinoma with tuberculosis was observed in 25.9 per cent of the cases. The tuberculous process was represented by more or less healed fibrous foci. There apparently existed no etiologic relationship between the two. They have observed in 10.4 per cent of their cases a combination of bronchial cancer with active open forms of tuberculosis. These lesions represented either a flaring up of old reinfections with a breaking down and the appearance of tubercle bacilli in the sputum as a result of the direct effect on it of a new growth, or an activation of an old process as the result of weakening of the organism by the malignant process. The two processes develop most frequently in the same lung but not in the same localization.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

83: 1199-1316 (March 18) 1939. Partial Index

Use of Papain, a Fibrin-Splitting Ferment, to Prevent Formation of Peritoneal Adhesions. J. P. Kellerman Slotemaker.—p. 1207.
Survival Time of Transfused Erythrocytes. H. J. N. Dekkers.—p. 1212.
*Boron as Antiepileptic. A. Verjaal.—p. 1226.
Treatment of Multiple Sclerosis. A. Biemond.—p. 1234.

Boron as Antiepileptic.—In order to determine the value of boron as an antiepileptic, Verjaal employed it in 100 adults with epilepsy who reacted inadequately to large doses of bromine and phenobarbital or similar substances. He substituted boron preparations for a part of the other medicaments. He always gave the boron preparation in combination with phenobarbital, at first in a combination suggested by Willemse, later in the following combination, which caused less complications: phenobarbital 0.075 Gm., sodium borate 0.500 Gm. and boric acid 0.500 Gm. Powders made up of this combination were given from one to three times a day and in exceptional cases four times. Boron preparations may be given in fluid as well as in powder form, but when given in combination with phenobarbital the powder form is to be preferred. The epileptic patients who were treated with this combination previously had had several epileptic seizures weekly, in spite of the regular use of large doses of phenobarbital. The combined administration of phenobarbital and boron preparation arrested the seizures completely in thirteen patients, and in twenty-seven patients the number of seizures was reduced to less than one third. Among the undesirable complications that may result from medication with boron preparations the author mentions exanthem, gastrointestinal disturbances, increase in temperature, albuminuria, alopecia areata and emaciation. Discussing these complications and their causes, the author points out that, since boron preparations are a constituent of some popular reducing remedies, the physician should consider the possibility of boron poisoning when patients exhibit some of the aforementioned toxic symptoms. The diagnosis of boron poisoning can be based on the presence of boron in the urine. Studies on the metabolism of boron preparations suggested that their favorable effect on epilepsy can be ascribed to their action on the biologic condition of the organism.

83: 1317-1442 (March 25) 1939. Partial Index

Histologic "Grading According to Martzloff" of Squamous-Cell Cancers of Cervix Uteri in Connection with Prognosis and Irradiation. P. J. van Gulik.—p. 1333.
Gastrorrhexis Caused by Fermentation of Gastric Contents. J. H. Lichtenbelt.—p. 1340.
*Serum from Convalescents in Combating Mortality from Measles. W. A. Timmerman.—p. 1346.
Prophylaxis of Measles. H. I. de Ruiter.—p. 1356.

Convalescent Serum in Measles.—Timmerman says that, although the mortality from measles has somewhat decreased in recent years, measles is still comparatively dangerous. A table which indicates the mortality per hundred thousand of population for measles, scarlet fever, whooping cough and diphtheria shows that the mortality from measles comes right after that of whooping cough and is much higher than the mortality from scarlet fever and diphtheria. The mortality is greatest among children less than 5 years of age and it is therefore important that these children be given protection. As a rule it is an older child of a family, one going to school, who first comes in contact with measles, but fortunately these older children are not so much in need of protection. On the day on which the exanthem appears in the first child, that is, when the definite diagnosis is made, the other children should be subjected to prophylactic serotherapy. The author emphasizes that protection is especially important for children less than 3 years old and for all children of any age who have another disorder. He reports the efficacy of convalescent serum in ninety-eight children, some of whom lived in home surroundings and some in various institutions (children's hospitals, sanatoriums and so on). In twenty-three cases partial protection was aimed at and it was accomplished in twenty-two cases; in one case the resulting protection was complete. In seventy-five cases complete protection was the purpose, which was successful in fifty; in twenty cases a slight morbilloid resulted, in five no influence of the serum on the course of the disease was seen. A table which lists the dosages employed reveals that for complete protection from 3 to 12 cc. is given, the larger doses being administered to older children and in the later stages of incubation. In remarks about the possibility of substituting placental extract for convalescent serum the author says that the placental extracts are likely to cause undesirable complications and that, until they have been further improved, convalescent serum is to be preferred.

Acta Obstet. et Gynec. Scandinavica, Stockholm

18: 245-358 (No. 3) 1938. Partial Index

*Treatment of Abortion. F. Holtz.—p. 245.
*Roentgenologic Diagnosis of Placenta Praevia. E. Petersen.—p. 275.
Experiences with Method for Lessening Pains of Labor with Nitrous Oxide. S. Karlson.—p. 285.
Traumatic Diabetes Insipidus and Pregnancy: Case. E. Brattström.—p. 320.
Primary Sarcoma of Fallopian Tube: Case. B. Jörgensen.—p. 326.
Insertio Furcata Funiculi Umbilicalis. O. Herberz.—p. 336.

Treatment of Abortion.—Holtz collected and analyzed 2,718 cases of abortion, 1,372 of which were reexamined at the end of four years of observation. Regarding the early abortions, that is, those developing during the first three months, the author says that in the uncomplicated cases without severe hemorrhage the immediate as well as the late results were better after active treatment: infection spread less frequently, the mortality was lower, the patients were bedfast for a shorter period and sterility followed less often than was the case after conservative treatment. The better results of the active treatment were especially noticeable in febrile cases. The evacuation after a prolonged course was followed comparatively often by a spreading infection, development of secondary anemia, prolonged rest in bed and sterility. Evacuation at the feverish stage did not seem to impair the results of active treatment, but to a certain extent abundant bleeding had an aggravating effect. Summarizing his observations on late abortions, that is, on those occurring between the fourth and seventh month of gestation, the author says that the result of expectant treatment was good both in feverish and in nonfeverish cases. In the majority of cases fetus as well as placenta passed spon-

taneously and completely. In the cases in which placental retention occurred, the result of active treatment was more satisfactory (lower morbidity and shorter period in bed) than that of conservative treatment. In these cases likewise the result of evacuation after a prolonged course was less satisfactory. These observations show that in cases of early abortion without complications the treatment should be active; in cases of late abortion, on the other hand, it should be expectant, except in placental retention, in which case evacuation should be induced.

Roentgenologic Diagnosis of Placenta Praevia.—Petersen reviews the method of the roentgenologic diagnosis of placenta praevia, which was described by Ude and Urner in the *American Journal of Obstetrics and Gynecology* **29**:667 (May) 1935. The method is a cystography, that is, 40 cc. of a 12.5 per cent solution of sodium iodide is instilled into the bladder after it has been emptied. Petersen says that he used this method with satisfactory results in several cases. In the presence of placenta praevia a free space appears in the roentgenogram between the fetal head and the bladder. The method permits the diagnosis of placenta praevia centralis and partialis and it confirms the absence of placenta praevia in the cases in which there is no space between the fetal head and the maternal bladder.

19: 1-111 (No. 1) 1939

Case of Thrombosis of Umbilical Vein in One of Uniovular Twins. A. Ingelman-Sundberg.—p. 1.
*Menstrual Disturbances Treated with Follicular Hormones. H. Anker.—p. 9.
Prognosis of Manual Removal of Placenta and Possible Predisposing Factors of Retained Placenta. E. Schie.—p. 28.
Justification of Rupture of Bag of Waters and Their Relations to Opening of Cervix. J. Kreis.—p. 52.
Studies on Duration of Birth in Finland: Rapidity of Opening of Uterine Os, Time of Rupture of Bag of Waters and Rapidity of Passage of Head Through Birth Canal. A. M. Ritala.—p. 63.

Estrogen in Treatment of Menstrual Disturbances.—Anker treated seven cases of menorrhagia, including six of the juvenile type, with large doses of estrogen. In two cases the cycle became regular after the treatment, the loss of blood being of normal strength and duration. In three others the treatment was followed by a decrease in the strength and the duration of the hemorrhages, but the cycle did not become regular; on the contrary, amenorrhea of several months' duration developed before menstruation set in again. In two cases the menorrhagia persisted after the treatment but the severity was lessened. One of the latter cases was not of the juvenile type. Curettage in three of the cases of juvenile menorrhagia showed the usual histologic picture of that disease, namely glandular hypoplasia of the endometrium with twisted glandular tubes of increased number, depth and width. The author concludes from this that the mucosa is influenced by the corpus luteum hormone rather than, as is usually assumed, that the function of the corpus luteum is deficient in these cases. Consequently the disorder should be treated with estrogen rather than with progesterone. In five cases of secondary amenorrhea or oligomenorrhea the author gave estrogen either alone or in combination with progesterone. Three patients responded to the treatment with menstrual bleeding, in two cases the infantile symptoms were improved and one woman, who had been sterile for a year, became pregnant.

Bibliotek for Læger, Copenhagen

131: 51-100 (Feb.) 1939

*Uratic Arthritis. K. Brøchner-Mortensen.—p. 51.

131: 101-172 (March) 1939

*Uratic Arthritis. K. Brøchner-Mortensen.—p. 101.

Uratic Arthritis.—On the basis of the literature and on his observations in the twenty-six cases reported, Brøchner-Mortensen discusses the diagnosis of uratic arthritis. A typical history and acute attacks, he says, are the most certain aids in diagnosis. Subcutaneous uratic tophi, verified by the murexide test, while pathognomonic for uratic arthritis, are inconstant and are usually a late symptom; roentgenologically demonstrable defects in the bones are of more frequent occurrence and appear earlier but they are not pathognomonic. Hyperuricemia, which occurs in about two thirds of the cases and is almost always present when the condition has lasted for some years, also appears in other disorders. The amount of endogenic uric acid eliminated is the same as in normal persons. The renal function measured by the creatinine and urea clearance is normal in most cases. After intravenous or oral purine loading, an increase of at least 50 per cent, usually considerably more, is seen in the urea clearance in normal persons; in patients with uratic arthritis the increase is on the whole less marked. There is apparently a renal threshold for uric acid, corresponding to 4 or 5 mg. per hundred cubic centimeters of uric acid in the serum on the average in normal persons, somewhat higher in patients with uratic arthritis. Attempts at inducing acute attacks by the administration of foods containing purine or by a ketogenic diet maintained for a longer time as a rule gave negative results. Signs of a slight reduction of the liver function or injury of the liver parenchyma were found in twelve of the twenty-six patients. There was polycythemia in three patients and anemia in two. In acute attacks of uratic arthritis the sedimentation speed of the erythrocytes was generally increased. In six cases with a picture reminding one of the "atypical uratic arthritis" described in the literature, the history failed to support the diagnosis, and until the theoretical possibility of such cases without acute attacks is supported further by definite observations and until the knowledge of the etiology and pathogenesis of true rheumatism is more complete the author advises conservatism in diagnosing "atypical uratic arthritis."

Finska Läkaresällskapets Handlingar, Helsingfors

81: 1053-1176 (Nov.) 1938

*Occurrence and Significance of Stasis Albuminuria. M. C. Ehrström.—p. 1149.

Stasis Albuminuria.—Ehrström says that stasis albuminuria, usually slight, occurs in about half of all cases of cardiac insufficiency. When severe, hypoproteinemia and nephrotic edemas may develop. It is more frequent and more severe in cases with hypertension and valvular defects of the aorta than in other cardiac insufficiencies. In hypertension the condition may perhaps depend on latent renal injury; in those with defects of the aortic valves, on the great frequency of syphilis.

Nordisk Medicin, Helsingfors

1: 207-269 (Jan. 28) 1939

Duodecim

Lumbar Sympathectomy. M. Hämäläinen.—p. 219.
Bovine Type as Cause of Tuberculosis in Man. J. Pikkarainen.—p. 224.
Patho-Anatomic Research and Nature of Tumors. A. Saxen.—p. 227.
*Renal Complications Due to Gonorrhea. Lauri Kalaja.—p. 230.

Renal Complications Due to Gonorrhea.—Kalaja says that according to Uhle only thirteen of the cases of renal complications due to gonorrhea reported up to 1934 are certain and a lesion of the infected kidney had already occurred in nearly all the cases. He reports a case of pararenal abscess in connection with gonorrheal renal infection. The patient, a man aged 25, had had a slight purulent discharge from the urethra, which ceased spontaneously. A month later chills and fever set in, with increasing abdominal pain. A large pararenal abscess was discovered on the left side. By repeated puncture more than 750 cc. of pus was removed. Conservative treatment was followed by recovery. The urine and smears of the pus from the abscess contained gram-negative diplococci, and gonococci were established in culture from the urine; there was also a definite complement binding reaction.

1: 415-486 (Feb. 18) 1939

*Ovarian Tumors with Inner Secretory Action. H. Bergstrand.—p. 415.
Features of Pathology of Musical Functions. H. J. Ustvedt.—p. 420.

Ovarian Tumors with Inner Secretory Action.—Bergstrand says that the granulosa tumors are usually unilateral and occur at all ages, though rarely in children. Often three histologically different forms appear in the same tumor. The tumors have cancer-like and sarcoma-like formations but are generally benign. Large amounts of estrogen are secreted and demonstrable both in the serum and in the urine. Before the climacteric the tumors are associated with irregularities in menstruation and uterine hemorrhages; after the climacteric hemorrhages dominate. The musculature of the uterus is

hypertrophic, the mucous membrane is hyperplastic and the glands of the mucous membrane become cystically distended. In rare cases virilism or hirsutism is seen. The Brenner tumors, although they cause no inner secretory phenomena, are probably a variant of the granulosa tumors. They are benign, are as a rule unilateral, and occur after the climacteric. The theca cell tumors, also probably a variant of the granulosa tumors, are macroscopically fibroma-like, with the configuration of the ovary and yellow softer parts; microscopically they resemble the diffuse form of the granulosa tumors. Hemorrhages occur after longer or shorter peiods of amenorrhea. Sometimes there is virilism. Luteinomas are unilateral, have a characteristic yellow appearance because of the fat-filled cells, and both macroscopically and microscopically suggest a large corpus luteum. With these tumors virilism and amenorrhea are more regular symptoms. Pathogenically the four tumor types named belong to a common group. Disgerminomas, usually bilateral, occur at puberty and a large percentage cause metastases. Histologically their structure is identical with that of seminomas of the testis. In rare cases symptoms belonging to the adrenogenital syndrome are connected with them. Many of the tumors described as arrhenoblastomas are believed to be granulosa tumors. In their most differentiated form they are said to consist of tubuli; in other cases the structure is complicated with alternating sarcomatous and carcinomatous parts which merge into one another; the first type is benign, the second malignant.

Norsk Magasin for Lægevidenskapen

1: 487-566 (Feb. 25) 1939

*Pulmonary Metastases: 148 Cases. T. J. Olsen.—p. 499.
Investigations on Prognosis of Schizophreniform Psychoses with Special Regard to Question of Shock Treatment. G. Langfeldt.—p. 507.
Medicolegal Evaluation of Fracture of Neck Found in Drowned Man. F. Harbitz.—p. 513.
Encephalitis with Acute Parkinsonism. F. Lorentzen.—p. 518.
Treatment of Acute Poliomyelitis. K. Zeiner-Henriksen.—p. 521.
Investigations on Vitamin C Balance in Asylum Patients. O. J. Broch.—p. 525.

Pulmonary Metastases.—Olsen reports 119 cases of carcinoma and twenty-nine of sarcoma in which pulmonary metastases were diagnosed from 1932 to 1936. Excluding the cases of cancer of the breast and of the genitals there was a slight preponderance in men. About 4 per cent of the patients were under 40. Most of the patients died within a year, ten lived more than a year and two lived about two years. Of the forty patients with physical abnormalities over the lungs, thirty-three had cancer of the breast, in which involvement of the pleura is more common. The author says that in seminoma testis there seems to be a special type of metastasis, in many sarcomas there is a ball-like metastasis, and nearly half of the cases of cancer of the breast have a characteristic x-ray appearance; otherwise neither the histology of the primary tumor nor its localization determines the type of metastasis seen in the x-ray examination of the lung. With regard to lymphatic permeation, there was no case of pulmonary metastasis in cancer of the breast in which the patient had been operated on radically and given postoperative radium treatment as soon as possible. The results of roentgen treatment in thirteen cases of pulmonary metastasis are reported. A conformity seems to exist between the radiosensitivity of the primary tumor and the pulmonary metastasis. The radiosensitivity was marked in a case of malignant melanoma, one of osteogenic sarcoma and especially two cases of metastasis from seminomas. The treatment was well borne and temporary benefit followed.

Svenska Läkaresällskapets Handlingar, Stockholm

64: 1-122, 1938

*Periodic Fever. E. Ask-Upmark.—p. 1.
Gullstrand's Farbenmischung Apparatus. G. F. Olsson.—p. 94.

Periodic Fever.—By periodicity Ask-Upmark means the occurrence of fairly regular pyrexial cycles, usually lasting several days. Among 346 patients with tumors of the skeletal system, diseases of the blood, lymphogranulomatosis, hyperparathyroidism and renal tumors, there were thirty-eight positive and forty-six probably positive instances of periodic fever. The period of fever as a rule averaged from eight to twelve days. Periodicity was especially noticeable in Ewing's sarcoma and in the severe anemias, particularly in the more or less aplastic cases. When the anemias improved, the fever gradually disappeared. Puncture of the bone marrow and a reticulocyte count pointed to a stimulation of hemopoietic activities during the attacks of fever, and the author concludes that periodic fever in tumors of the bone and diseases of the blood is connected with involvement of the bone marrow. He says that the periodic fever present in undulant fever, rat-bite fever, relapsing fever, trench fever, kala-azar, dengue and some other conditions may also be explained by involvement of the pathologic process of the reticulo-endothelial system in general and the bone marrow in particular and that these structures may presumably be affected in other infectious disorders. The periodic fever in malignant lymphogranulomatosis (Pel-Ebstein phenomenon) can be accounted for by the theory that periodicity is inherent in the functional activity of the reticulo-endothelial system. Enlargement of the affected spleen or lymph nodes may correspond to periods of fever. The fever after splenectomy is not infrequently typically periodic and may be ascribed to compensatory adjustments taking place in other parts of the reticulo-endothelial system. The stimulation of blood regeneration connected with splenectomy may be understood from the same point of view. The fever, often periodic, which occurs in hyperparathyroidism and disappears following removal of the parathyroid adenoma, may depend on the pathologic processes in the bone marrow. In pernicious anemia the degree of fever was found to be definitely related to the severity of the anemia, and often periodic. Involvement of the reticulo-endothelial system is also suggested in cases of fever in certain intoxications. With regard to malignant tumors in general, fever as a rule occurs especially in tumors of the hemopoietic system, which, the author asserts, seems to corroborate his general conception that periodic fever is to be encountered mainly in diseases affecting the bone marrow or the reticulo-endothelial system.

Ugeskrift for Læger, Copenhagen

101: 231-258 (Feb. 23) 1939

Clinical Investigations on Diabetes Diet Containing More Abundant Carbohydrates With and Without Insulin: Third Report. M. Lauritzen.—p. 231.
Orthopedic Treatment of Poliomyelitis. A. Berntsen.—p. 236.
New Application of Sedimentation Reaction in Differential Diagnosis of Liver Diseases. S. Toft.—p. 240.
*Fatal Epinephrine Intoxication. H. Gormsen.—p. 242.
Child Psychiatry: II. Infantile and Juvenile Paralytic Dementia. G. K. Stürup.—p. 245

Fatal Epinephrine Intoxication.—Gormsen reports that a man, aged 42, with a history of bronchial asthma, treated earlier with injections of epinephrine and later with inhalation of a 10 per cent epinephrine solution in spray, used 0.6 cc. of this preparation (60 mg. of epinephrine) in subcutaneous injection through a misunderstanding. Death resulted in a few minutes. Necropsy showed hyperemia of all organs. Microscopic examination disclosed capillary and venous stasis in nearly all the organs, while the arteries in many places were empty. In the lungs there were edema and extensive hemorrhages. Small interstitial hemorrhages appeared in the kidneys. The author says that of the twenty-eight cases previously reported which are ascribed to acute epinephrine intoxication, the only certain cases are the five he cites, all due to overdosage by mistake. In two of these cases a 1 per cent solution of epinephrine was injected instead of a procaine-epinephrine solution; in the others procaine hydrochloride dissolved in a 1 per cent solution of epinephrine was used instead of the commonly applied small amount of epinephrine in a 1 per cent procaine solution. The symptoms were immediate pain in the neck, anxiety, pallor, vomiting, dyspnea, increased pulse rate and collapse, which, in connection with marked rise in the blood pressure, are like the phenomena of hyperadrenalemia paroxysms in chronic chromaffin tumors. The minimum lethal dose for subcutaneous injection seems to be about 10 mg. of epinephrine. While the histologic picture in fatal epinephrine intoxication is apparently fairly characteristic, neither the macroscopic nor the microscopic changes are specific, and since epinephrine because of rapid destruction in the blood cannot be established in the organs or blood, analyses of eventual remains of the solution used must be the decisive factor in medicolegal examination of cases attributed to epinephrine overdosage.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-JUNE 1939

Titles have been listed or Abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past six months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1929. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

Acta Chirurgica Scandinavica. Stockholm.
Acta Medica Scandinavica. Stockholm.
Acta Medica URSS. Moscow.
Acta Obstetricia et Gynecologica Scandinavica. Stockholm.
Acta Orthopaedica Scandinavica. Copenhagen.
Acta Pædiatrica. Stockholm.
Acta Radiologica. Stockholm.
Acta Tuberculosea Scandinavica. Copenhagen.
American Heart Journal. St. Louis.
American Journal of Cancer. New York.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Huntington, Ind.
*American Journal of Diseases of Children. A. M. A., Chicago.
American Journal of Hygiene. Baltimore.
American Journal of Medical Jurisprudence. Boston.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. St. Louis.
American Journal of Orthopsychiatry. Menasha, Wis.
American Journal of Pathology. Boston.
American Journal of Physiology. Baltimore.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine. Baltimore.
American Review of Tuberculosis. New York.
Anales del Instituto Modelo de Clínica Médica. Buenos Aires.
Annales de Médecine. Paris.
Annales Pædiatrici. Basel.
Annali Italiani di Chirurgia. Bologna.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Medical History. New York.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of Surgery. Philadelphia.
Archiv für Dermatologie und Syphilis. Berlin.
Archiv für Gewerbepathologie und Gewerbehygiene. Berlin.
Archiv für Gynäkologie. Berlin.
Archiv für Kinderheilkunde. Stuttgart.
Archiv für klinische Chirurgie. Berlin.
Archiv für orthopädische und Unfall-Chirurgie. Berlin.
Archiv für Verdauungs-Krankheiten. Basel.
*Archives of Dermatology and Syphilology. A. M. A., Chicago.
Archives of Disease in Childhood. London.
*Archives of Internal Medicine. A. M. A., Chicago.
Archives des Maladies de l'Appareil Digestif. Paris.
Archives des Maladies du Cœur. Paris.
Archives Médico-Chirurgicales de l'Appareil Respiratoire. Paris.
Archives de Médecine des Enfants. Paris.
*Archives of Neurology and Psychiatry. A. M. A., Chicago.
*Archives of Ophthalmology. A. M. A., Chicago.
*Archives of Otolaryngology. A. M. A., Chicago.
*Archives of Pathology. A. M. A., Chicago.
Archives of Physical Therapy. Chicago.
*Archives of Surgery. A. M. A., Chicago.
Archivio Italiano delle Malattie dell'Apparato Digerente. Bologna.
Archivio Italiano di Anatomia e Histologia Patologica. Bologna.
Archivio Italiano di Chirurgia. Bologna.
Archivio Italiano di Urologia. Bologna.
Archivos Argentinos de Neurología. Buenos Aires.
Archivos Argentinos de Pediatría. Buenos Aires.
Archivos de Medicina Infantil. Havana.
Archivos de Pediatría del Uruguay. Montevideo.
Archivos Uruguayos de Medicina, Cirugía y Especialidades. Montevideo.
Arquivo de Patologia. Lisboa.
Australian Journal of Experimental Biology and Medical Science. Adelaide.
Australian and New Zealand Journal of Surgery. Sydney.
Beiträge zur klinischen Chirurgie. Berlin.
Beiträge zur Klinik der Tuberkulose. Berlin.
Bibliotek for Læger. Copenhagen.
Biochemica e Terapia Sperimentale. Milan.
Boletín Academia Nacional de Medicina de Buenos Aires. Buenos Aires.
Boletín de la Sociedad Cubana de Pediatría. Havana.
Bollettino dell'Istituto Sieroterapico Milanese. Milan.
Brain. London.
Brasil-Medico. Rio de Janeiro.
Bristol Medico-Chirurgical Journal.
British Journal of Anaesthesia. Manchester.
British Journal of Children's Diseases. London.
British Journal of Dermatology and Syphilis. London.
British Journal of Experimental Pathology. London.
British Journal of Medical Psychology. London.
British Journal of Ophthalmology. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Tuberculosis. London.
British Journal of Urology. London.
British Medical Journal. London.
Bruxelles-Médical. Brussels.
Bulletin de l'Association Française pour l'Etude du Cancer. Paris.
Bulletin of the Health Organisation of the League of Nations. Geneva.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the Neurological Institute of New York. New York.
Bulletin of the New York Academy of Medicine. New York.
California and Western Medicine. San Francisco.
Canadian Medical Association Journal. Montreal.
Canadian Public Health Journal. Toronto.
Chinese Medical Journal. Peiping.
Chirurg. Berlin.
Clinical Science. London.
Delaware State Medical Journal. Wilmington.
Dermosifilografo. Turin.
Deutsches Archiv für klinische Medizin. Berlin.
Deutsche medizinische Wochenschrift. Leipzig.
Deutsche Zeitschrift für Chirurgie. Berlin.
East African Medical Journal. Nairobi.
Edinburgh Medical Journal.
Encéphale. Paris.
Endocrinology. Los Angeles.
Finska Läkaresällskapets Handlingar. Helsingfors.
Folia Haematologica. Leipzig.
Folia Medica. Naples.
Fortschritte auf dem Gebiete der Röntgenstrahlen. Leipzig.
Gazzetta degli Ospedali e delle Cliniche. Milan.
Geneeskundig Tijdschrift voor Nederlandsch-Indië. Batavia.
Giornale di Batteriologia e Immunologia. Turin.
Giornale di Clinica Medica. Parma.
Giornale di Psichiatria e di Neuropatologia. Ferrara.
Glasgow Medical Journal.
Guy's Hospital Reports. London.
Gynécologie et Obstétrique. Paris.
Helvetica Medica Acta. Basel.
Hospitalstidende. Copenhagen.
Illinois Medical Journal. Chicago.
Indian Journal of Medical Research. Calcutta.
Indian Medical Gazette. Calcutta.
International Journal of Psycho-Analysis. London.
Irish Journal of Medical Science. Dublin.
Jahrbuch für Kinderheilkunde. Basel.
Jornal dos Clinicos. São Paulo.
Journal of Allergy. St. Louis.
Journal of the Arkansas Medical Society. Fort Smith.
Journal of Aviation Medicine. St. Paul.
Journal of Bacteriology. Baltimore.
Journal Belge de Neurologie et de Psychiatrie. Brussels.
Journal of Bone and Joint Surgery. Boston.
Journal de Chirurgie. Paris.
Journal of Clinical Investigation. New York.
Journal of Connecticut State Medical Society. Hartford.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Hygiene. London.
Journal of Immunology. Baltimore.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Industrial Hygiene and Toxicology. Baltimore.
Journal of Infectious Diseases. Chicago.
Journal of Investigative Dermatology. Baltimore.
Journal of Iowa State Medical Society. Des Moines.
Journal of Kansas Medical Society. Topeka.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal-Lancet. Minneapolis.
Journal of Laryngology and Otology. London.
Journal of the Maine Medical Association. Portland.

*Cannot be lent.

Journal of Medical Association of State of Alabama. Montgomery.
Journal of Medical Association of Georgia. Atlanta.
Journal of Medical Society of New Jersey. Trenton.
Journal de Médecine de Lyon. Lyons.
Journal of Mental Science. London.
Journal of Michigan State Medical Society. Lansing.
Journal of Missouri State Medical Association. St. Louis.
Journal of the Mount Sinai Hospital. New York.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology and Psychiatry. London.
Journal of Neurophysiology. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Obstetrics and Gynaecology of British Empire. Manchester.
Journal of Oklahoma State Medical Association. McAlester.
Journal of Pathology and Bacteriology. Edinburgh.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of the Philippine Islands Medical Association. Manila.
Journal of Physiology. London.
Journal de Radiologie et d'Electrologie. Paris.
Journal of the Royal Institute of Public Health and Hygiene. London.
Journal of South Carolina Medical Association. Greenville.
Journal of Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Tropical Medicine and Hygiene. London.
Journal d'Urologie Médicale et Chirurgicale. Paris.
Journal of Urology. Baltimore.
Kentucky Medical Journal. Bowling Green.
Kinderärztliche Praxis. Leipzig.
Klinicheskaya Meditsina. Moscow.
Klinische Monatsblätter für Augenheilkunde. Stuttgart.
Klinische Wochenschrift. Berlin.
Lancet. London.
Laryngoscope. St. Louis.
Lyon Chirurgical. Paris.
Maandschrift voor Kindergeneeskunde. Leyden.
Medical Annals of the District of Columbia. Washington.
Medical Bulletin of the Veterans' Administration. Washington, D. C.
Medical Journal of Australia. Sydney.
Medicine. Baltimore.
Medizinische Klinik. Berlin.
Medizinische Welt. Berlin.
Mental Hygiene. Albany, N. Y.
Military Surgeon. Washington, D. C.
Minnesota Medicine. St. Paul.
Monatsschrift für Kinderheilkunde. Berlin.
Monatsschrift für Psychiatrie und Neurologie. Basel.
Münchener medizinische Wochenschrift. Munich.
Nebraska State Medical Journal. Lincoln.
Nederlandsch Tijdschrift voor Geneeskunde. Amsterdam.
Nederlandsch Tijdschrift voor Verloskunde en Gynaecologie. Haarlem.
Nervenarzt. Berlin.
New England Journal of Medicine. Boston.
New Orleans Medical and Surgical Journal.
New York State Journal of Medicine. New York.
New Zealand Medical Journal. Wellington.
Nordisk Medicin. Helsingfors.
Nordisk Medicinsk Tidskrift. Stockholm.
Norsk Magasin for Lægevidenskapen. Oslo.
Northwest Medicine. Seattle.
Novyy Khirurgicheskiy Arkhiv. Dnepropetrovsk.
Ohio State Medical Journal. Columbus.
Orvosi Hetilap. Budapest.
Oto-Rino-Laringologia Italiana. Bologna.
Pennsylvania Medical Journal. Harrisburg.
Physiological Reviews. Baltimore.
Practitioner. London.
Prensa Médica Argentina. Buenos Aires.
Presse Médicale. Paris.
Problemy Tuberkuleza. Moscow.
Psychiatric Quarterly. Utica, N. Y.
Psychoanalytic Quarterly. Albany, N. Y.
Public Health Reports. Washington, D. C.
Puerto Rico Journal of Public Health & Tropical Medicine. San Juan.
Quarterly Journal of Medicine. Oxford.
Radiology. Syracuse, N. Y.
Rassegna Internazionale di Clinica e Terapia. Naples.
Review of Gastroenterology. New York.
Revista de la Facultad de Medicina. Bogotá.
Revue Belge des Sciences Médicales. Louvain.
Revue de Chirurgie. Paris.
Revue Française de Pédiatrie. Paris.
Revue Médico-Chirurgicale des Maladies du Foie. Paris.
Revue Neurologique. Paris.
Revue d'Orthopédie et de Chirurgie de l'Appareil Moteur. Paris.
Rhode Island Medical Journal. Providence.
Riforma Medica. Naples.
Rivista di Chirurgia. Naples.
Rivista di Clinica Medica. Florence.
Rivista di Patologia e Clinica della Tubercolosi. Bologna.
Rocky Mountain Medical Journal. Denver.
Sang. Paris.
Schweizerische medizinische Wochenschrift. Basel.
South African Medical Journal. Cape Town.
Southern Medical Journal. Birmingham, Ala.
Southern Surgeon. Atlanta, Ga.
Southwestern Medicine. El Paso, Texas.
Sovetskiy Vrachebnyy Zhurnal. Leningrad.
Strahlentherapie. Berlin.
Strasbourg Médical. Strasbourg.
Surgery. St. Louis.
Surgery, Gynecology and Obstetrics. Chicago.
Texas State Journal of Medicine. Fort Worth.
Tohoku Journal of Experimental Medicine. Sendai.
Tubercle. London.
Ugeskrift for Læger. Copenhagen.
United States Naval Medical Bulletin. Washington, D. C.
Upsala Läkareförenings Förhandlingar. Uppsala.
Vestnik Khirurgii. Leningrad.
Virginia Medical Monthly. Richmond.
Vrachebnoe Delo. Kharkov.
Western Journal of Surgery, Obstetrics and Gynecology. Portland, Ore.
West Virginia Medical Journal. Charleston.
Wiener Archiv für innere Medizin. Vienna.
Wiener klinische Wochenschrift. Vienna.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.
Zeitschrift für Geburtshülfe und Gynäkologie. Stuttgart.
Zeitschrift für die gesamte experimentelle Medizin. Berlin.
Zeitschrift für die gesamte Neurologie und Psychiatrie. Berlin.
Zeitschrift für Immunitätsforschung. Jena.
Zeitschrift für Kinderheilkunde. Berlin.
Zeitschrift für klinische Medizin. Berlin.
Zeitschrift für Krebsforschung. Berlin.
Zeitschrift für menschliche Verebungs- und Konstitutionslehre. Berlin.
Zeitschrift für Tuberkulose. Leipzig.
Zeitschrift für urologische Chirurgie. Berlin.
Zeitschrift für Urologie. Leipzig.

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "SS," Student Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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SOCIETIES

Acad.—Academy
Am.—American
A.—Association
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical
Med.—Medicine
Nat.—National
Phys.—Physicians
Phar.—Pharmaceutical
Rev.—Revision
Ry.—Railway
Soc.—Society
Surg.—Surgery
Surgs.—Surgeons
S.—Surgical

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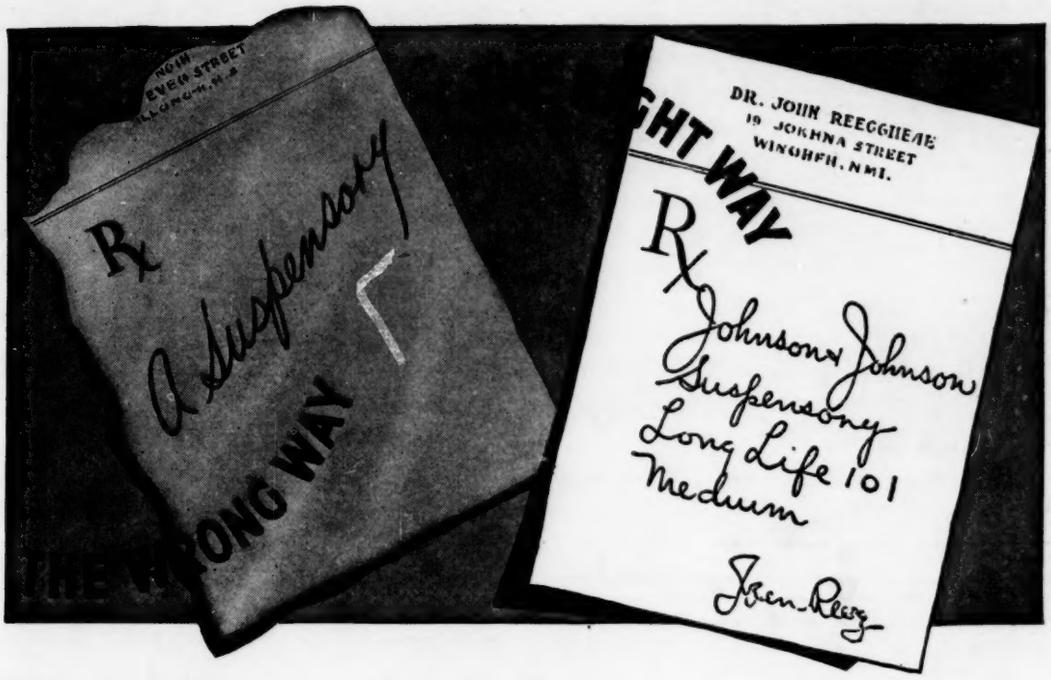

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